Maternal and Child Health Services Title V Block Grant

California

Appendix to the FY 2017 Application

FY 2015 Annual Report

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Appendix 1 References

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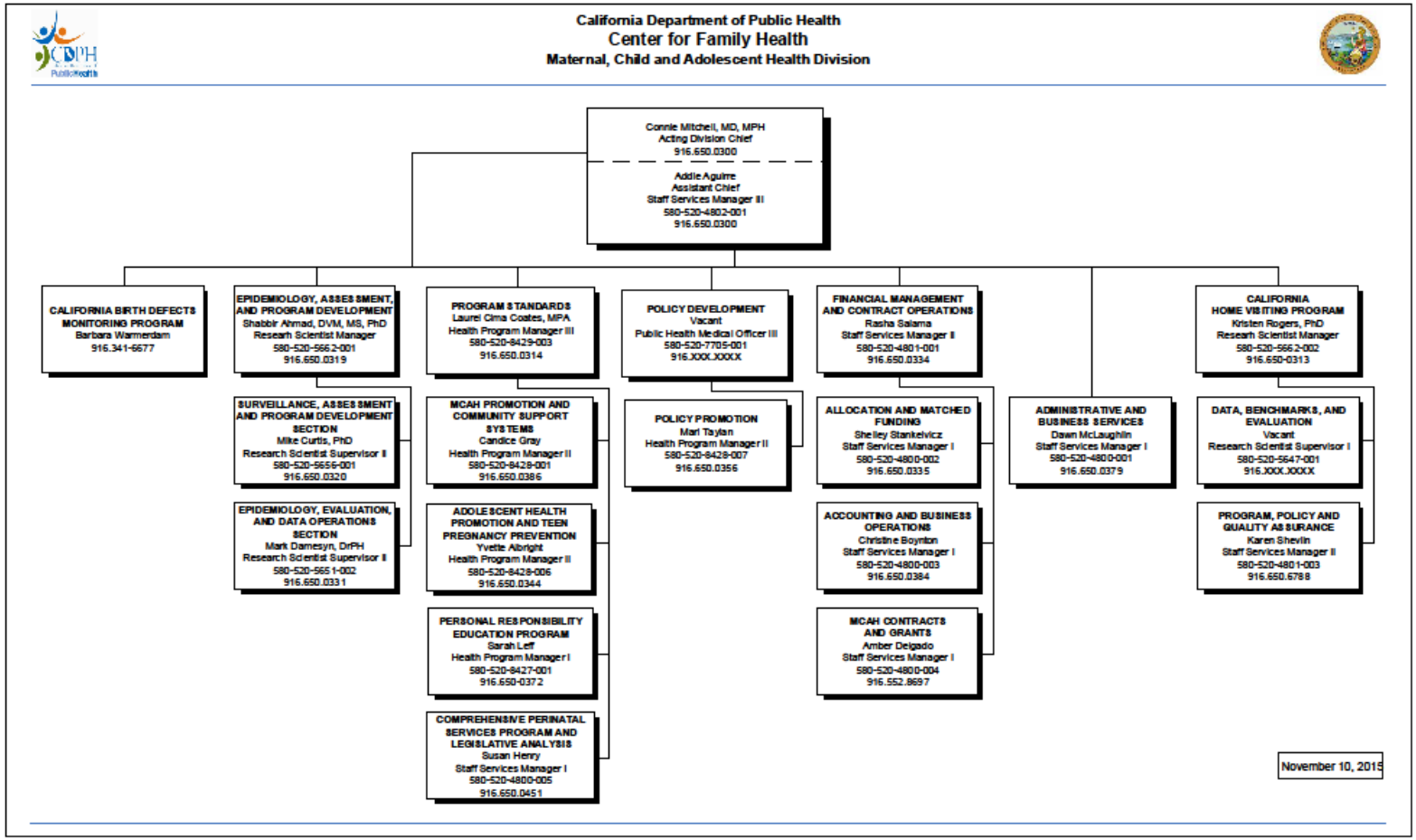
Appendix 2 Glossary of Acronyms

A	AAP	American Academy of Pediatrics
	ACA	Affordable Care Act of 2010
	AFLP	Adolescent Family Life Program
B	BIH	Black Infant Health
C	CAMMIS	California Medicaid Management Information System
	CalMHSA	California Mental Health Services Authority
	CA PREP	State of California Personal Responsibility Education Program
	CCS	California Children's Services
	CDAPP	California Diabetes and Pregnancy Program
	CDC	Centers for Disease Control and Prevention
	CDPH	California Department of Public Health
	CFH	Center For Family Health
	CHDP	Child Health and Disability Prevention
	CHVP	California Home Visiting Program
	CMQCC	California Maternal Quality Care Collaborative
	CoIIN	Collaborative Improvement and Innovation Network
	CPQCC	California Perinatal Quality Care Collaborative
	CPSP	Comprehensive Perinatal Services Program
	CRAFFT	Car, Relax, Alone, Family or Friends, Trouble
	CRISS	Children's Regional Integrated Services System
	CSHCN	Children with Special Health Care Needs
	CTCP	California Tobacco Control Program
	CYSHCN	Children and Youth with Special Health Care Needs
D	DC	Developmental Centers
	DDS	Department of Developmental Services
	DHCS	Department of Health Care Services
	DME	durable medical equipment
	DSS	Department of Social Services
E	EPSDT	Early and Periodic Screening, Diagnosis and Treatment
	ESM	Evidence-based or- informed Strategy Measure
F	FASD	Fetal Alcohol Spectrum Disorder
	FHOP	Family Health Outcomes Project
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FTE	Full-time equivalent
G	GDSP	Genetic Disease Screening Program
H	HIV	Human Immunodeficiency Virus

I	I&E	Information and Education Program
	ICPC	Interconception Care Project of California
	IPV	Intimate Partner Violence
L	LA	Los Angeles
	LBW	Low Birth weight (<2500 grams)
	LHJ	Local Health Jurisdiction
	LARC	Long-acting reversible contraceptives
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MHSA	Mental Health Services Act
	MMCD	Medi-Cal Managed Care Division
	MOD	March of Dimes
	MTP	Medical Therapy Program
N	NGA	National Governor's Association
	NICU	Neonatal Intensive Care Unit
	NOM	National Outcome Measure
	NPM	National Performance Measure
	NSCSHCN	National Survey of Children with Special Healthcare Needs
O	OHU	Oral Health Unit
P	PHN	Public Health Nurse
	PHSP	Preventive Health and Safety Protocol
	PHCC	Preconception Health Council of California
	PHSP	Preventive Health and Safety Practices
	PICU	Pediatric Intensive Care Unit
	PPCW	Pediatric Palliative Care Waiver
	PYD	Positive Youth Development
R	RFA	Request for Application
	RPPC	Regional Perinatal Programs of California
	RSAB	Redesign Stakeholder Advisory Board
S	SAC	Safe and Active Communities
	SCCs	Special Care Centers
	SCD	Systems of Care Division
	SIDS	Sudden Infant Death Syndrome
	SMART	Specific, Measureable, Achievable, Realistic and Time-based
	SOW	Scope of Work
	SPM	State Performance Measure
T	TA	Technical Assistance

V	VLBW	Very Low Birth weight (<1500 grams)
W	WIC	Women, Infants, and Children Supplemental Nutrition Program

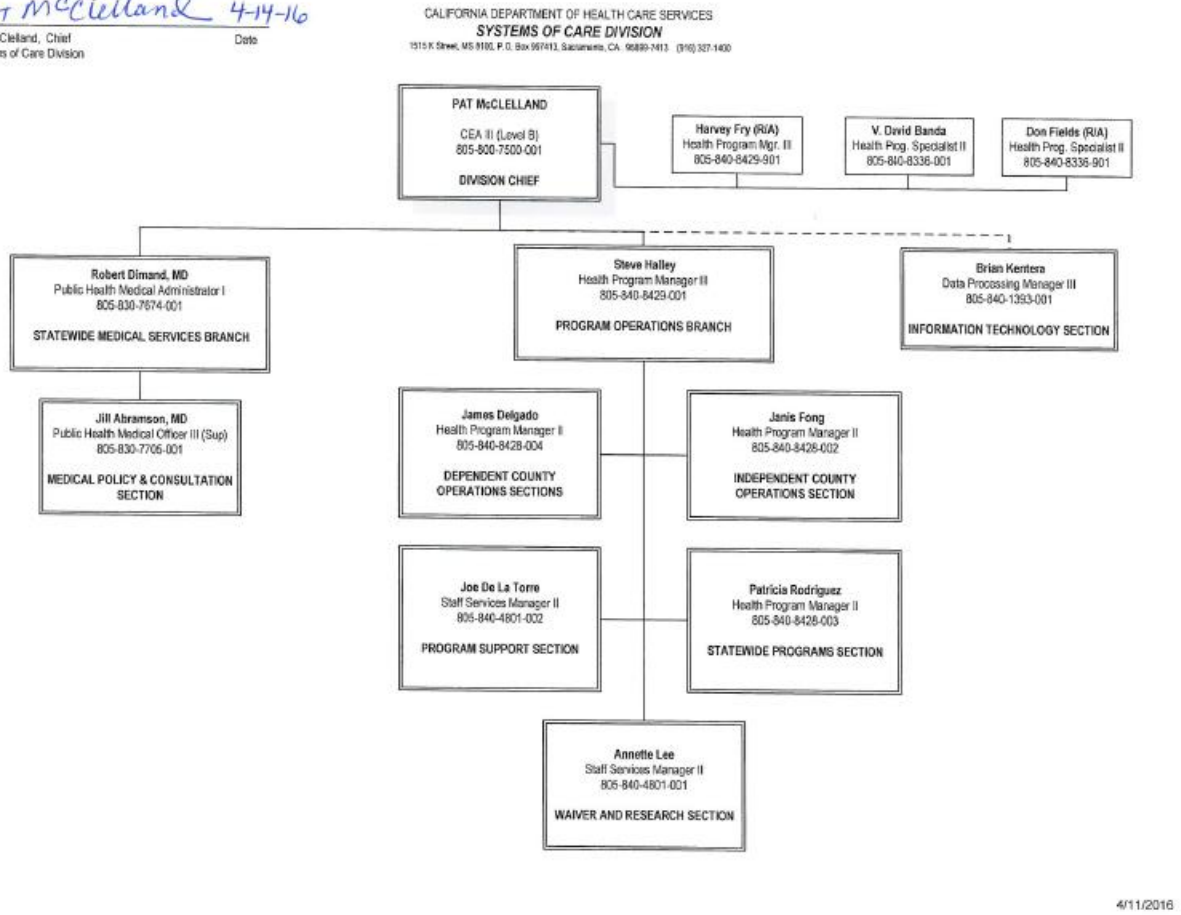
Appendix 3 Organization Charts
CDPH Maternal, Child and Adolescent Health Division



DHCS Systems of Care Division

Pat McClelland 4-14-16

Pat McClelland, Chief — Date
Systems of Care Division



Appendix 4 Public Input

Comment (Children Now – Oral Health):
We applaud the application's recognition of oral health as a major factor in one's overall health under this domain (Goal 1: Increase Access to Oral Health, pages 79-80). Generally, we believe the objectives for this goal must be bolder and higher reaching – that is, much fewer uninsured Medi-Cal eligible women and children, and much higher rates of children with a preventive dental visit (such as a 10 percentage point increase or a 2020 target of 85.3%). The age range for these metrics should also be expanded to include children beyond the 3-11 age range and to align with CMS data reporting standards already used by DHCS.

Goal 1 will be strengthened by greater articulation and description of the specific roles that CDPH will play, particularly in how local health jurisdictions will be supported by CDPH, a description of the "limited dental services" some LHJs provide to target populations, and how CDPH's strategies will contribute to an increase in Denti-Cal enrollment and dental utilization. Additionally, CDPH should express how it will ensure the appropriate staffing (e.g., oral health consultant, associate, dentist, etc. beyond the Oral Health Unit and the State Dental Director) to provide necessary support and guidance to LHJs in service of CDPH's oral health goals and strategies. To help with the efforts focused on oral health promotion or disease prevention, we suggest exploring close partnerships with other MCAH programs, including the Comprehensive Perinatal Services Program (CPSP), Black Infant Health Program (BIH), and the California Home Visiting Program (CHVP).

Response to (Children Now – Oral Health):
Thank you for your comments and suggestions. We have revised the draft version of the Title V application and report to reflect the age range and goals stated in the State Oral Health Plan.

We recognize the importance of oral health for all people, especially children and pregnant women, and are committed to improving access, addressing barriers, and increasing utilization of oral health services for our population. The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health Program is partnering with CDPH's Oral Health Program to implement the State Oral Health Plan. For more information, please review this brief presentation (http://www.cdph.ca.gov/programs/mcah/Documents/MCAHStatewide.Kumar.OralHealth.2016.pdf) of the State Oral Health Plan that includes an overview, data, a framework for public health action, and proposed strategies.

Comment from (Children's Partnership – Oral Health)
Integration: *We would like to add that oral health should be integrated into all maternal and child health activities to fully leverage both efforts.*
California Home Visiting Program*: We recommend including mention of the role oral health plays in home visiting programs and identify where the Title V plan intersects with the forthcoming State Oral Health Plan to benefit both efforts.*

Needs Assessment: *As a part of the Title V Needs Assessment, it would be helpful to include a needs assessment of the oral health needs of children and pregnant women and to make sure that the needs assessment and subsequent process and outcomes metrics are aligned with the objectives of the State Oral Health Plan.*
Alignment of age range: *The age range and all other objectives under Title V should be changed to be in alignment with the objectives of the State Oral Health Plan. "SMART OBJECTIVE: By June 30, 2020, increase the rate of children 3-11 years with a dental visit in the last year from 75.3 percent 2011/12) to 79.1."*

Response for (Children's Partnership – Oral Health):
Thank you for your comments. The organization of the Title V may inadvertently give the impression that MCAH activities are more disjointed than they are. While oral health is mentioned in several domains, it is a focus for the entire MCAH population. Activities such as messaging and referrals for service are provided for women before, during and after pregnancy, infants at birth (starting with feeding), children, and adolescents.

Among the many MCAH programs that have a strong oral health component is the California Home Visiting Program (CHVP). Because the CHVP is not a Title V funded program, a full description of its program features is not detailed in the report and application, however the Health Reform section of the report details the collaborative efforts in place with CHVP to address disparities in insurance coverage and access.

The Title V Needs Assessment was conducted during a time of transition when the Oral Health Director had not yet been hired and the MCAH Oral Health Consultant had recently retired. Because of limited expertise, it is not featured as prominently as we would like. With the recent addition of these positions, MCAH oral health efforts are in alignment with the State Oral Health Plan and a plan is in place to assess and address ongoing and emerging needs as they arise.

With the increased emphasis on early dental visits, this objective has been aligned with the national performance measure - By June 30, 2020, increase the rate of children ages 1-17 years who received a preventive dental visit in the last year from 75.3 percent (2011/12) to 79.1 percent. The baseline percent figure will remain the same because it was for the 1-17 year old group. Because the baseline is from 2011, Plan, a 10% improvement will be applied to align with the State Oral Health Plan.

Comment (The Children's Specialty Care Coalition –Perinatal Objective):
The California Association of Neonatologists is one of our members and recommends the addition of another perinatal and infant mortality objective to increase perinatal diagnosis and referrals to complex care centers before birth.

Response to (The Children's Specialty Care Coalition –Perinatal Objective):
MCAH will consider additional objectives in the next application year and are working with our stakeholders regarding these complex care issues. Additionally, MCAH currently tracks maternal risk assessment and levels of care. The Title V Application and Report include our activities toward specific goals selected from a limited menu offered by our federal funder, with an understanding that MCAH will track additional

relevant measures as part of routine public health surveillance. Identified within the application are the high priority goals, activities and measures; these are not the only measures MCAH will track during the five-year period.

Comment (Office of Health Equity - Intimate Partner Violence):
Domain Women/Maternal Health; Priority 1: I am particularly pleased with the inclusion of an objective around IPV and increasing the ability of local programs to address IPV. Violence is a key determinant of health and wellness; an increased focus on violence will support women and their children.

Response (Office of Health Equity -Intimate Partner Violence):
Thank you for comment. We value all voices! MCAH and partners are excited to take on this critical and important objective. For the last couple years, MCAH programs have been addressing violence in different forms through collaborations, health promotion and education activities, and trainings. However, there was not been a concerted effort within MCAH to provide programmatic framework approach to our programs. In 2014, the MCAH's Title V needs assessment stakeholder survey ranked domestic violence 6th as a maternal/ women's health emerging issues or unmet need, and violence was identified as the 7th most frequently reported problem.

The objective will provide local health jurisdictions and MCAH programs evidence-based guidance as to how to adopt a IPV Protocol, with the ultimate goal of decreasing IPV as outlined in MCAH's Title V Application.

Addressing IPV will also contribute to achieving the Governor's Let's Get Healthy California goal of "Creating Healthy Communities: Enabling Healthy Living". A leading indicator under this goal is to increase the percent of adults who report they feel safe. Reducing the public health burden of victimization is one of several factors that contribute to an atmosphere of living in a safe environment.

Comment (Office of Health Equity – Youth Resiliency):
Goal 2: Build Youth Resiliency and Coping Skills. Though I understand a shift to focus on bullying I'm concerned about eliminating an indicator around school enrollment. Educational attainment is a key determinant of health outcomes and MCAH programs should support families in attending school.

In addition, this may be planned, but is not explicit in the document - it would be useful to connect with the Department of Education around anti-bullying efforts.

Response to (Office of Health Equity – Youth Resiliency):
Thank you for your comment. MCAH was required to identify one of the national performance measures in the adolescent health domain. Among the options, reducing bullying was the best fit across all MCAH adolescent health programs. Though it is not included as a Title V indicator, educational attainment as a key social determinant of health remains a high priority for the Adolescent Family Life Program.

Though an exhaustive list of stakeholders was not included in the Action Plan, MCAH will connect with key stakeholders, including our state partners at the Department of Education, around anti-bullying efforts.

Comment (Office of Health Equity – Food Security):
I was really pleased to see the section on the drought and food security. These are key issues for many Californians and I look forward to seeing any actions MCAH is able to take in this area.

Response to (Office of Health Equity – Food Security and Drought):
Thank you for your comment. Food Security is an important issue to the CDPH and the MCAH Division. MCAH addresses community health and wellness issues (i.e., food security) from a Social Determinants of Health and life course perspective. We strive to ensure access and consumption of sustainable forms of nutritious foods to promote optimum health and infant growth before, during and after pregnancy. MCAH routinely monitors food security status among pregnant women through the annual Maternal and Infant Health Assessment (MIHA) Survey. MIHA surveillance tables are available at: www.cdph.ca.gov/miha.

Our CPSP, AFLP, BIH and Home Visiting Programs ask clients about their food security status and makes a point of referring eligible clients to the WIC Program and the CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP). Examples of resources provided include the CPSP Steps to Take handouts You Can Stretch Your Dollars: Choose These Easy Meals and Snacks (E &S) and You Can Buy Healthy Food on a Budget (E &S). Focusing on our new parents and babies, MCAH has a dedicated workgroup addressing "Lactation Accommodation of the Low Wage Worker," especially considering mothers working in agriculture.

As California mounts an evolving plan to address the drought, our understanding of the immediate impact of the drought expands. While there is clear link between drought and the food supply, public health is preparing for the impact of more extreme climatic conditions that may accompany climate change on health and well-being throughout the state. These extreme events (e.g. flooding, extreme heat, extreme cold) disrupt the physical, biological, and ecological systems. Consequences such as fire, flooding, air pollution, and vector breeding may lead to an increased risk of illness or injury, chronic conditions such as asthma, respiratory conditions and cardiovascular disease, and facilitate the spread of vector born disease such as Lyme, Dengue, West Nile and Zika. MCAH will continue to partner with emergency preparedness colleagues to forecast vulnerabilities for pregnant women and children and develop risk abatement and preventive strategies.

Comment (Office of Health Equity - Poverty and Housing):
II. State Overview: I appreciate the inclusion of poverty and housing. These are key social determinants of health and having a discussion about these in the MCH Services Report show a full understanding of their importance.

Response to (Office of Health Equity - Poverty and Housing):

Thank you for your comment. While we acknowledge that we cannot directly impact all of the social determinants of health, we prominently articulate our life course framework as the foundation to all of our work. This framing helps us understand the context of our work and participate in collaborative efforts, pilot projects, and evidence-informed models that address systems and environmental influences of health for MCAH populations.

Comment (Office of Health Equity – Social Service Utilization):
CA Priority Area 7: Increase access and utilization of health and social services. Though the priority includes "social" services, the National Performance Measure only looks at health insurance. Given the importance of the social determinants of health on outcomes, it would be interesting to identify a measure that also looks at access to other services (e.g., housing, child care subsidies, etc.).

Response to (Office of Health Equity – Social Service Utilization):
Thank you for your comment. As part of the MCAH Scope of Work, LHJs track referrals to ancillary services beyond Medi-Cal/Dent-Cal and Covered California; however, National Performance Measures are decided by the federal Maternal and Child Health Bureau (MCHB). MCHB has acknowledged that the SMART objectives developed by states may map to additional outcomes that are not captured in the list of available National Performance Measures. Housing and counseling/support referrals are among the additional services tracked.

Comment (Lucile Packard Foundation for Children's Health - Mental Health/Substance Use):
Increase Screening and Referral for Mental Health and Substance Use Services: This section of the application is notably weak in failing to outline specific mental health promotion programs for children and youth, maternal depression screening, and early identification of serious emotional disorders of adolescents and young adults.

Response for (Lucile Packard Foundation for Children's Health - Mental Health/Substance Use):
Thank you for your comments. The strategies listed in the Action Plan table are intended to contain a general guide to the activities that MCAH will perform each year. On pages 59-60 and 62 a more detailed synopsis of the activities from 2014-2015 and plans for 2016-2017 are provided. Therein is a description of specific mental health promotion activities, maternal depression screening, early identification, and substance use screening and treatment.

Comment (Children Now – Health Insurance):
We strongly endorse Goal 4 to Increase the Rates of Women, Children, and Adolescents who have Health Insurance (page 81). In fact, we highly recommend that CDPH consider a more aggressive 2020 target for the percent of children with health insurance, given DHCS' implementation of the SB 75 Medi-Cal expansion for undocumented children that went into effect on May 16, 2016. We also suggest articulating strategies, activities, and tools that LHJs can employ to connect children and families with coverage, such as the resources at the health4allkids.org website.

Response to (Children Now – Health Insurance):
Thank you for your feedback and suggestion. Given the changing healthcare environment, including the potential impact of the implementation of SB 75, which allows full scope Medi-Cal for all children, we will look into re-calibrating our target as part of our mid-course review, should we meet or exceed our objective before 2020.

We are developing guidelines to assist local health jurisdictions (LHJs) to adopt protocols, tailored to their local needs, to assist all clients in MCAH Programs or touched by the health department, to enroll in Medi-Cal, Covered California, or other health insurance, link clients to a provider and ensure they complete a preventive visit. Also, as part of the local Maternal, Child and Adolescent Health Scope of Work, all 61 LHJs are required to implement activities to increase access and utilization of health and social services, as resources allow. This includes addressing the social determinants of health and barriers to accessing preventive, medical, dental, and mental health services.

Comment (Lucile Packard Foundation for Children's Health – Physical Activity):
Increase Physical Activity within the MCAH Population: This section highlights the commitment to information sharing about physical activity, especially the use of a website containing resources. It is useful to remember that a website is not an intervention.

Response to (Lucile Packard Foundation for Children's Health – Physical Activity):
Thank you for your comment. We recognize that a website is not an intervention and recognize that its inclusion in the strategies could be misleading. The website serves as a resource platform for the dissemination of interventions (e.g. promising practices and evidence-informed strategies) for health professionals to address nutrition and physical activity.

Comment (Lucile Packard Foundation for Children's Health – Access):
Increase Access to High Quality Care (P.64): The application presents a goal of improving access to specialists; hopefully the intention is to increase access to pediatric subspecialists. It is not clear why a goal of 90% was chosen, as 100% would be a more appropriate goal. The data on which this goal is based is from family report. This should be supplemented by analyses of administrative data. In addition, though access to subspecialists is good proxy indicator of high quality care, it is not a direct or complete measure and thus is not sufficient on its own

Response for (Lucile Packard Foundation for Children's Health – Access):
DHCS is measuring access to pediatric sub-specialists as part of our new state performance measure.

Comment (Children's Regional Integrated Service System - Access to Special Care Centers):
Page 23: Linkage of State Selected Priorities with National Performance and Outcome Measures

We think that, important as a medical home is for CSHCN, the truly critical element to measure is easy access to appropriate and timely pediatric subspecialty care. We recommend that DHCS measure access to Special Care Centers and implement other indicators of access to subspecialty care.
CRISS comments: Future surveys of CCS families and providers to assess satisfaction with systems changes should be compared to FHOP surveys conducted for the 2015 Title V Needs Assessment

Response for (Children's Regional Integrated Service System - Access to Special Care Centers):
Agree. Access to subspecialists/special care centers is a new state performance.

Comment (Children's Regional Integrated Service System - Advisory Group):
"By June 30, 2020, increase the children enrolled in the California Children's Services (CCS) who receive primary and specialty care through a single system of care by 20%."
1. Through the CCS Advisory Group stakeholder process, refine the selected whole child approach to optimize access to qualified providers.
CRISS comments: As noted in comments below, the whole child model was chosen by DHCS, not the CCS Advisory Group. Many Advisory Group members continue to have concerns about the DHCS proposal

Response for (Children's Regional Integrated Service System - Advisory Group):
The model was chosen through the CCS advisory stakeholder engagement process.

Comment (Epilepsy California - CCS provider standards):
While we have not had enough time to adequately evaluate the draft application, we have identified a concern related to the Department's proposal to review the criteria for providers to be CCS-paneled in order to increase the number of CCS providers. We are concerned this could lead to changes that destabilize access to the regional network of CCS doctors, clinics and hospitals that serve children with special health care needs. The Department should provide more justification publicly for why such a change to these standards is necessary. CCS provides critically needed care to children with special health care needs, and it is not reasonable to propose changes to it as part of the Title V grant without more data, discussion and analysis.

Response for (Epilepsy California - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (California Chronic Care Coalition -CCS provider standards):
Provider Standards: On Page 36 under "Priority 5," the Department states a goal to increase access to CCS-paneled providers to ensure timely access to a qualified provider. While we share a commitment to timely and high quality care for children, the available data do not seem to provide information about the actual barriers for

CCS families who reported difficulty accessing a qualified specialist. We believe it is premature to propose revising the standards for paneling CCS providers without further knowledge about the challenges families are facing. This strategy should include additional studies into wait times and other access problems to better determine any recommendations on revising provider standards. The current CCS provider standards are intentionally high to ensure that children with complex medical conditions have access to the most qualified pediatric specialists for their condition(s), and that quality should not be compromised under any circumstances. Is the proposed outcome of ensuring a medical home the right measure to assess access to high quality specialists?

Response for (California Chronic Care Coalition –CCS Provider Standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers

Comment (Children's Regional Integrated Service System - CCS provider standards):
By June 30, 2020, increase the percent of CCS families reporting that their child always saw a specialist when needed from 72% to 90%, based on CCS/FHOP survey.
1. With CCS AG, explore strategies to increase access to CCS-paneled providers, with focus on rural areas, including streamlining process and developing reports of shortage areas.
CRISS comments: What process is DHCS proposing to streamline?

Response for (Children's Regional Integrated Service System - CCS provider standards):
DHCS is committed to maintaining access to subspecialists. Priority 5, SMART objective 1, Strategy number 1 will be modified to remove language relative to streamlining the process.

Comment (California Chronic Care Coalition - CCS provider standards):
PROPOSAL TO CHANGE CRITERIA FOR CCS-PANELED PROVIDERS. While we have not had enough time to adequately evaluate the draft application, we have more data, discussion and analysis. identified a concern related to the Department's proposal to review the criteria for providers to be CCS-paneled in order to increase the number of CCS providers. We are concerned this could lead to changes that destabilize access to the regional network of CCS doctors, clinics and hospitals that serve children with special health care needs. The Department should provide more justification publicly for why such a change to these standards is necessary. CCS provides critically needed care to children with special health care needs, and it is not reasonable to propose changes to it as part of the Title V grant without more data, discussion and analysis.

Response for (California Chronic Care Coalition - CCS provider standards):

Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (California Children's Hospital Association - CCS provider standards):
CCS clinical standards form the core of the program and are one of the reasons for its success. As such, we think it is extremely premature to propose revising the standards for paneling CCS providers without further analysis into where access problems with paneled providers are. We would recommend that this strategy be eliminated or revised to incorporate the need for more analysis into wait times and other indications of access problems in particular specialty areas that could inform further recommendations in this area. Finally, with respect to this measure, we believe that the outcome measure proposed by the Department is inadequate to evaluate whether the Department's proposed strategies achieved the objective. The appropriate measure should be whether timely access to a CCS specialist improved, not whether the child had a medical home. not only those children who receive services through CCS. These same providers that see CCS.

Response for (California Children's Hospital Association - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.
DHCS agrees with the recommendation that timely access to CCS sub specialists should be measured. DHCS will be measuring timely access to subspecialist care in the coming year.

Comment (California Children's Hospital Association - CCS provider standards):
The CCS program has developed rigorous clinical standards that providers must meet in order to treat children with CCS conditions. The standards ensure that these children obtain care from experienced providers with appropriate pediatric-specific expertise. For example, the program requires that cardiac surgery on neonates can only be performed by an appropriately credentialed, board certified pediatric cardiac surgeon. Similarly, the program requires that a pulmonary special care center must include a social worker and a dietician, to help address the psycho-social and dietary needs of patients with cystic fibrosis. The standards put in place by the CCS Program benefit patients also treat privately insured patientPriority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.
DHCS agrees with the recommendation that timely access to CCS sub specialists should be measured. DHCS will be measuring timely access to subspecialist care in the coming years. Thus, the high quality of care that is fostered and maintained by the CCS program benefits all California children with special health care needs. Moreover, research indicates that the types of standards adopted by the CCS program can have real world implications for improving health outcomes. For example, last year the American Journal of Cardiology published a longitudinal study

of regionalized pediatric specialty care and pediatric cardiac heart disease in California. The study concludes that over three decades, the use of the regionalized pediatric network of specialty providers – the same providers who are approved by the CCS program – increased while pediatric mortality from cardiac heart disease decreased. Research like this supports our view that CCS's credentialing and program standards must be maintained under any transition to managed care.

Response for (California Children's Hospital Association - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (California Children's Hospital Association - CCS provider standards):
Department's Proposal to Revise CCS Credentialing Standards Not Supported by Data. We are concerned about the Department's proposal to review the criteria for credentialing CCS providers. Specifically, on page 36 of the draft application, the Department states an objective to, "By June 30, 2020, increase the percent of CCS families reporting that their child always saw a specialist when needed from 72% to 90%, based on CCS/FHOP survey." One strategy the Department proposes to help achieve this objective is to "Review the criteria for providers to be CCS-paneled with the goal of increasing numbers of paneled providers while maintaining quality standards." We believe that this strategy is not supported by the data. The FHOP survey it references does not actually provide any information about what the current barriers are for the 28 percent of CCS families who reported that they could not always access a qualified specialist timely. That is, while the FHOP survey found that 72 percent of families reported that their child could always obtain access to specialty care when needed (and another 15 percent stated that they could "usually" obtain access to such care), the survey provides little insight into where the problems in accessing specialty care are, whether they originate with the CCS referral, utilization review process, provider's office, or elsewhere. The data does not support the notion that credentialing criteria are a barrier to accessing needed care.

Response for (California Children's Hospital Association - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (Children's Regional Integrated Service System - CCS provider standards):
Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
CRISS comments: We would like to see details on how DHCS would define and measure this

Response for (Children's Regional Integrated Service System - CCS provider standards):
"Percent of CSHCN receiving care in a well-functioning system" is a National Outcome Measure and DHCS cannot change the language.
DHCS currently reports access to sub specialty care as well as access to medical homes.

Comment (American Nurses Association - CCS provider standards):
The Department should provide more justification publicly for why such a change to these standards is necessary. CCS provides critically needed care to children with special health care needs, and it is not reasonable to propose changes to it as part of the Title V grant without more data, discussion and analysis.

Response for (American Nurses Association - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (American Nurses Association - CCS provider standards):
We have identified a concern related to the Department's proposal to review the criteria for providers to be CCS-paneled in order to increase the number of CCS providers. We are concerned this could lead to changes that destabilize access to the regional network of CCS doctors, clinics and hospitals that serve children with special health care needs.

Response for (American Nurses Association - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (Down Syndrome Information Alliance - CCS provider standards):
We are concerned this could lead to changes that destabilize access to the regional network of CCS doctors, clinics and hospitals that serve children with special health care needs. The Department should provide more justification publicly for why such a change to these standards is necessary. CCS provides critically needed care to children with special health care needs, and it is not reasonable to propose changes to it as part of the Title V grant without more data, discussion and analysis.

Response for (Down Syndrome Information Alliance - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (California Academy of PAs (CAPA) - CCS provider standards):
We are pleased the state action plan recognizes the need to review criteria for CCS-paneled providers and submit that inclusion of PAs as paneled providers, who practice in a team environment with a CCS paneled physician and surgeon, would be

consistent with the state action plan priorities and, in fact, serve to help meet the aforementioned state priorities.

Response for (California Academy of PAs (CAPA) - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (Children's Regional Integrated Service System - CCS provider standards):
2. Based on the findings of the Title V needs assessment, define issues associated with non-participation in CCS of durable medical equipment, pharmacy, home health and behavioral health providers, and explore methods to increase their participation in CCS.
3. Review the criteria for providers to be CCS-paneled with the goal of increasing numbers of paneled providers while maintaining quality standards.
CRISS comments: What leads DHCS to think that provider paneling criteria present a major access barrier? Numerous research papers suggest the role of other barriers such as extremely low Medi-Cal rates and payment delays, compounded by geographic barriers in rural areas, as well as the general inadequacy of the pediatric subspecialty workforce for all children, regardless of insurance status. None of those papers suggests changing provider paneling criteria as a solution; in fact, some explicitly cite the importance of CCS program standards in creating and maintaining the state's pediatric system of care. We strongly recommend against any strategies that would reduce CCS quality standards and instead urge DHCS to look at other drivers in access barriers, including reimbursement rates.

Response for (Children's Regional Integrated Service System - CCS provider standards):
Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (The Children's Specialty Care Coalition - CCS provider standards (Telehealth)):
Priority 5 (page 36), "Increase the access to CCS paneled providers such that each child has timely access to medically necessary care by a qualified provider." The third proposed strategy for this objective, "review the criteria for providers to be CCS paneled," is particularly concerning. The current CCS paneling criteria ensures that CCS eligible children obtain care from experienced providers with appropriate pediatric-specific expertise. Research has demonstrated that access to pediatric subspecialty care is associated with higher quality of care, improved outcomes and reduced costs, compared to care given by adult specialists. The CCS paneling standards should not be diminished. Instead, we urge the Department to focus on recruitment and retention strategies, as well as wider utilization of telehealth as noted in the action plan. Careful consideration should be given to reasons for lack of provider participation, and the inadequacy of the pediatric subspecialty workforce in California.

Strategies that could be employed include loan repayment programs and medical school incentives for pediatric sub-specialization, evaluation of reimbursement rates, which have been historically low in California, and better utilization of physician extenders within the medical health team. An additional strategy to increase access to specialists is improved alignment and communication between primary care providers and specialists. Electronic referrals from primary physicians to specialty physicians, with the use of appropriate care guidelines, would greatly improve access and efficiency. E-referrals would help cut down on unnecessary referrals to specialists and will create efficiencies because pre-screening will already be done, resulting in patients arriving with test results, x-rays and laboratory work-up already completed.Additionally, we are very supportive of the increased use of telehealth to improve timely access to qualified providers and are pleased to see that as the second SMART Objective under Domain 5. In rural areas of the state, patients often must drive several hours to access a CCS provider. We see the utilization of modern technology as a critical means of increasing access. CSCC has learned that efforts led by, The Children's Health Partnership, are underway to work in collaboration with DHCS to identify issues related to current billing codes for telehealth for CCS.

Response for (The Children's Specialty Care Coalition - CCS provider standards (Telehealth)):

Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (Children's Regional Integrated Service System - CCS provider standards (Telehealth)):

Page 64: Goal 4: Increase Access to High Quality Care
SMART OBJECTIVE: By June 30, 2020, increase the rate of CCS families reporting that their child always saw a specialist when needed from 72% to 90% based on the CCS/FHOP survey.
CRISS comments: As discussed in an earlier comment, we are concerned if DHCS believes that CCS provider paneling criteria present a major barrier in children's access to appropriate specialty care. As we noted earlier, research papers concerning access to pediatric specialty care in California report the role of other barriers such as extremely low Medi-Cal rates and payment delays, compounded by geographic barriers in rural areas. Research also confirms the general inadequacy of the pediatric subspecialty workforce for all children, regardless of insurance status. None of the papers suggests changing provider paneling criteria as a solution; in fact, some explicitly cite the importance of CCS program standards in creating and maintaining the state's pediatric system of care. We strongly recommend against any strategies that would reduce CCS quality standards and instead urge DHCS to look at other drivers in access barriers, including reimbursement rates.

Response for (Children's Regional Integrated Service System - CCS provider standards (Telehealth)):

Priority 5, SMART Objective 1, Strategy number 3 has been removed from the application. DHCS will explore strategies to increase access to CCS- paneled providers.

Comment (Lucile Packard Foundation for Children's Health - Child Health and Disability Prevention Program):
Child Health and Disability Prevention Program (P.66): CHDP is superficially described without the provision of data on its operation or plans for its future work. The latter is of special note as California has expanded Medi-Cal to cover undocumented children which ought to substantially impact the CHDP program.

Response for (Lucile Packard Foundation for Children's Health - Child Health and Disability Prevention Program):
Thank you for your feedback.

Comment (Language Speech and Hearing Specialist -early intervention services):
Thank you for the focus on children and youth, especially children with special health care needs. I am a mom with young children. I am also a speech therapist working with young children, in particular children from low socio-economic backgrounds. In this capacity, I see the impact of lack of language and literature exposure from birth to 3 years. I would be wonderful if you could connect with Early Intervention Services (e.g., Alta, etc.) and work to increase parent education how to talk, play, and read with their children.

Response to (Language Speech and Hearing Specialist -early intervention services):
Thank you for your feedback and suggestion. We plan to offer a training to local MCAH program staff in Fall 2016 on the State of California, Department of Developmental Services, Early Start Program (http://www.dds.ca.gov/earlystart/index.cfm) which will include information on the role of Regional Centers. We also provide technical assistance to our local health jurisdictions (LHJs) to utilize the Birth to 5:Watch Me Thrive! (http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive) materials in their programs. Birth to 5: Watch Me Thrive! encourages healthy child development, promotes developmental and behavioral screening for all children and support for families and providers who care for children and youth with special health care needs. MCAH supports our partner, First 5 California's, statewide media campaign Talk, Read, Sing (http://www.first5california.com/) that encourage parents and caregivers to talk, read, play and sing to their babies and toddlers to stimulate brain growth and development.

Comment (Children Now – Developmental Screening):
We strongly commend CDPH for focusing on Goal 1: Provide Developmental Screening for All Children, and we are pleased to continue to support MCAH towards this goal – most recently on a May 18, 2016 conference call with the Maternal, Child, and Adolescent Health Directors on the topic of developmental screenings data and billing. Children Now particularly appreciates being recognized as a collaborator with MCAH, and we look forward to working closely with MCAH staff and LHJs around low-cost activities and partnerships related to developmental screenings for very young children

Response to (Children Now – Developmental Screening):
Thank you for your comment. We look forward to continuing our relationship, improving our knowledge of evidence based or informed activities that promote developmental screening, referral and linkages to early intervention services for all children and providing technical assistance to local health jurisdictions (LHJs) to make progress towards this goal.

Comment (Lucille Packard Foundation for Children's Health - Developmental Screening):
Fourteen years ago California participated in a multi-state learning collaborative to increase developmental screening, with pilot programs in Alameda County and the Inland Empire. The current proposed goal to "Provide Developmental Screening for All Children" to achieve a proposed 1% increase in screening rates from 28.5% to 29.5% evidences a longstanding and continuing lack of commitment on the part of the state to increase identification of children with developmental problems. The proposed activities are a potpourri of uncoordinated approaches all of which have been tried previously and none of which are likely, in their current form, to substantially improve early identification and access to intervention services. Particularly troubling is the lack of partnerships with health plans and child health care providers upon whose actions developmental screening depends.

Response to (Lucille Packard Foundation for Children's Health - Developmental Screening):
Thank you for your comments and suggestions. California Department of Public Health, Maternal, Child and Adolescent Health (CDPH MCAH) Program has multiple, competing priorities such as perinatal substance use and access and utilization of health care for our population. Regardless of our limited resources, CDPH MCAH has always identified the health of women and children as our priority. Over the past two years we have worked to increase our understanding of the issues around developmental screening, referral and linkage, developed relationships with strategic partners and are beginning to implement activities to improve rates of developmental screening, beginning with children in MCAH programs. Our initial efforts included providing information and education to MCAH Directors and their colleagues about the American Academy of Pediatrics screening guidelines, presentations and local examples of Help Me Grow (http://helpmegrownational.org/) implementation in local health jurisdictions (LHJs), and working with partners, including the Department of Health Care Services, California Children's Services on identifying billing codes and sharing data. We have submitted a proposal to the California Health Interview Survey (CHIS) to include a question on developmental screening in the 2017-18 CHIS survey. All 61 LHJs now have a requirement in their MCAH Scope of Work to implement activities, from a list of suggestions developed in collaboration with our partners, to increase developmental screening, referral and linkage. We are developing guidelines to assist LHJs to adopt protocols, tailored to local needs, to ensure that all children in MCAH Programs or touched by the health department are provided developmental screening, referral and linkage to services. MCAH is committed to improving services for all children, children and youth with special health care needs, first in local MCAH programs and then by working with providers and communities as resources allow.

Comment (Children's Regional Integrated Service System - Family engagement):
2. Increase the number of family members providing input into state and local transition practices.
CRISS comments: We strongly support increased family involvement in state and local transition planning and initiatives, as well as in planning for their own children's transitions

Response for (Children's Regional Integrated Service System - Family engagement):
Agree. DHCS is taking steps to increase family engagement in CCS policy development including transition.

Comment (Children's Regional Integrated Service System - Family Engagement):
Page 92: II.F.3. Family Consumer Partnership
CRISS comments: This section describes state and local activities to promote family consumer partnerships. We are proud that CRISS is cited as a partner with the state in involving families in policy planning and service development, and we appreciate the several earlier references in the application to the state's interest in increased family involvement in state and local CCS planning and oversight. We do feel, however, that overall that there should be a great deal more attention to family engagement in the application and in the state's approach to the CCS program, including plans for specific steps to increase family engagement at the state level. To that end, we recommend that the state increase family representation on the CCS Advisory Group, the body charged with advising the state on its plans for CCS redesign and for improvements to the current program. (There currently are only two official family representatives on this body.) If DHCS moves ahead with its whole child model in COHS counties, we also recommend that the Department establish a statewide whole child model stakeholder advisory group with strong representation from family resource organizations.

Response for (Children's Regional Integrated Service System - Family Engagement):
The Advisory Group is currently a large stakeholder group. There are 33 members on the board. Families and family resource organizations are encouraged to participate at all meetings during the public comment period as well as submit their input to CCSRedesign@DHCS.CA.gov. This suggestion will be forward to the CCS Redesign Advisory Group.

Comment (Family Voices of California - Family engagement):
As noted in the Title V MCH Block Grant Guidance: Family/Consumer Partnership: For purposes of the Title V MCH Services Block Grant program and this guidance, as previously noted, family/consumer partnership is defined as: "The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level." States will

describe efforts to support Family/Consumer Partnerships, including family/consumer engagement in the following strategies and activities:
- *Advisory Committees;*
- *Strategic and Program Planning;*
- *Quality Improvement;*
- *Workforce Development;*
- *Block Grant Development and Review;*
- *Materials Development; and*
- *Advocacy*

Response for (Family Voices of California - Family engagement):
DHCS is taking steps to increase family engagement in CCS policy including transition.

Comment (Children's Regional Integrated Service System - General):
CRISS comments: Future surveys of CCS families and providers to assess satisfaction with systems changes should be compared to FHOP surveys conducted for the 2015 Title V Needs Assessment.

Response for (Children's Regional Integrated Service System - General):
One of the CCS Title V strategies is to repeat the Title V family survey periodically to monitor satisfaction with CCS over time.

Comment (Lucile Packard Foundation for Children's Health - Health Care Program for Children in Foster Care):
Health Care Program for Children in Foster Care (P.67) is a good example of the integration of public health and child welfare services. The extent of its use and evidence of its impact is not provided. As is the case nationally, the presumed overuse of psychotropic medication by children in foster care is a topic of current interest within the state. However, the underlying problem of accessing appropriate mental health services is not addressed.

Response for (Lucile Packard Foundation for Children's Health - Health Care Program for Children in Foster Care):
Thank you for your feedback.

Comment (Lucile Packard Foundation for Children's Health - High Risk Infant Follow Up Program):
The High Risk Infant Follow Up Program (P.65) is a good example of a coordinated statewide approach to quality assurance. However the relationship of that program to other components of the state's child health care system remains poorly defined.

Response for (Lucile Packard Foundation for Children's Health - High Risk Infant Follow Up Program):
DHCS is taking steps to link HRIF to CCS programs.

Comment (Children's Regional Integrated Service System - Managed Care):

3. With CCS Advisory Group, review options for CCS clients to have a visit with an adult physician through managed care.
CRISS comments: See our comments below on transition and recommendation that the state set and Medi-Cal managed care plans be required to meet network adequacy standards for transitioning youth, including increased opportunities for single case agreements if there are no specialists in plan networks appropriate to youths' medical conditions.

Response for (Children's Regional Integrated Service System - Managed Care):
Managed Care plans are required to meet network adequacy standards today. The Department is committed to a public stakeholder process under which youth transitions include access to providers will be discussed.

Comment (Children's Regional Integrated Service System - Managed Care):
Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
CRISS comments: We would like to see details on how DHCS would define and measure this.

Response for (Children's Regional Integrated Service System - Managed Care):
DHCS is committed to providing children to affordable high quality health care.

Comment (Children's Regional Integrated Service System - Medical Home):
NPM 11: Percent of children with and without special health care needs having a medical home
CRISS comments: We recommend that for purposes of this priority DHCS measure children's access to pediatric sub-specialists and Special Care Centers, not medical homes.

Response for (Children's Regional Integrated Service System - Medical Home):
DHCS is mandated to report on the specific National Performance Measure - NPM 11 which is specifies measuring the number of children with a medical home.

Comment (Lucile Packard Foundation for Children's Health - Medical homes):
Increase Access to Medical Homes for CYSHCN (P.64): Medical homes remain undefined and apparently unmeasured. The goal to increase access is weakened by the failure to name a desired rate; rather an increase in the current rate is proposed. No plans are provided as to how increase access to medical homes will be achieved.

Response for (Lucile Packard Foundation for Children's Health - Medical homes):
DHCS is expecting to improve measurement of the percent of CCS clients with medical home by aligning the definition used in the CCS medical home performance measure with the national medical home measure.

Comment (Children's Regional Integrated Service System - Medical Homes):
Page 64: Goal 2: Increase Access to Medical Homes for CYSHCN

SMART OBJECTIVE: By June 30, 2020, increase the number of CYSHCN who receive care within a medical home by 20% as measured by the medical home CCS performance measure.
CRISS comments: CRISS supports a clearer, more consistent definition of medical home for CSHCN as well as standardized methods to measure achievement of the goal.
As CRISS representatives have recommended at CCS Advisory Group meetings, we urge DHCS to build on earlier work on medical homes for CCS children begun several years ago under Dr. Marian Dalsey's leadership of state CMS.

Response for (Children's Regional Integrated Service System - Medical Homes):
DHCS is committed to continuous, ongoing discussions with stakeholders pertaining to CCS and medical homes and how appropriate measurements should occur.

Comment (Lucile Packard Foundation for Children's Health - Medical Therapy Program):
The Medical Therapy Program (P.66) is a unique, clinical service available to children in California with disabilities. The application describes the existing program, but provides no information on utilization or impact, and fails to explore how this program does or could contribute to improvements in the overall child public health system in the state.

Response for (Lucile Packard Foundation for Children's Health - Medical Therapy Program):
Thank you for your feedback.

Comment (Family Voices of California - NICU):
Page 65 – Typo on number of children
Infants discharged from CCS-approved NICUs with CCS-eligible medical conditions or who are at high risk to develop such conditions are followed in a CCS HRIF Program. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.
Total # of individual children served between Jan 1, 2015 – Dec 31, 2015 =1,075,910,759.

Response for (Family Voices of California - NICU):
Correction made.

Comment (California Hepatitis C Task Force - Organized system of care):
CCS Redesign Stakeholder Advisory Group: The DHCS suggests that the CCS Redesign Stakeholder Advisory Board concluded the San Mateo model was successful. However, the stakeholder group has not made such a determination, nor has it been given any data to develop this conclusion. In fact, the Stakeholder Advisory Board has not even agreed upon what outcome measures should be used to evaluate the San Mateo model. The DHCS has selected the San Mateo model for expansion to other counties but it does not seem to have considered the feedback from the advisory group in this matter.

Response for (California Hepatitis C Task Force - Organized system of care):
DHCS did not select the Health Plan of San Mateo Demonstration Project pilot for expansion into other counties. DHCS embarked on an extensive six-month stakeholder process for stakeholder feedback in seeking a better integrated and coordinated system, to proceed carefully with changes to the CCS program, and to identify strategies to improve and integrate care for children who qualify for the CCS program. From that process, DHCS developed the "Whole-Child Model" to be implemented in specified counties only.

Comment (A CYSHCN client - Organized system of care):
They also seem to think that this model will work in the 19 other counties with a single County Organized Health System, that they plan to implement as part of phase 2. My county, Merced County, is hardly like San Mateo. San Mateo has three major hospitals within a one hour drive, as well as access to a large number of providers. Merced County is significantly underserved and all major medical facilities/hospitals, except Children's Hospital of Madera, are at least 2 hours away Coupled with that, we also have a high percentage of Medi-Cal patients. I am struck by the fact that DHCS feels this one-size-fits-all approach is the way to provide health care for medically fragile children like me. Each county needs to have the opportunity to come up with a plan that fits that county's demographics and works for the CCS children residing in that county.

Response for (A CYSHCN client - Organized system of care):
Thank you for your comment and your concern will be forwarded to the DHCS CCS Redesign team.

Comment (Children's Regional Integrated Service System - Organized system of care):
SMART OBJECTIVE: By June 30, 2020 increase the children in CCS who received primary and specialty care through a single system of care by 20%.
CRISS comments: We remain concerned that the Department continues to equate "organized delivery system" with Medi-Cal managed care and to assume that the only way for CSHCN to experience coordinated primary and specialty care is to receive both through managed care plans. In our view the CCS program is an "organized delivery system", one that is organized specifically for the needs of CSHCN. It contains essential elements of an organized delivery system, including a defined network of credentialed providers, utilization management and pre-authorization of services, and quality monitoring and improvement activities. It is true that primary care typically is delivered through a parallel system for these children, but we believe that coordination of primary and specialty care can be achieved while retaining the integrity of the CCS program. For most children enrolled in CCS, the most important medical relationships they have are with their pediatric subspecialists, and that is the arena in which the CCS program holds the expertise and experience. In addition, several county CCS programs in the state already have launched or are in the process of launching initiatives for better coordination with primary care and authorization of primary care providers for CCS-related care. In our view it will be simpler and safer to broaden the role of CCS in coordinating with primary care than to ask managed care plans to develop the expertise needed to oversee the treatment of

children with complex medical conditions. We recommend that DHCS support and promote county CCS programs' efforts to coordinate with and authorize primary care services for CCS children.

Response for (Children's Regional Integrated Service System - Organized system of care):
The Department is not implying CCS is not an organized delivery system. Rather that the Whole-Child Model will incorporate both primary and specialty care in one system allowing the state to accomplish the identified SMART objective.

Comment (California Children's Hospital Association - Organized system of care):
Add Reference to Rady Children's Hospital's CCS Pilot. On Page 33 of the draft, the Department identifies three strategies to achieve the following objective: "By June 30, 2020, increase the children enrolled in the California Children's Services (CCS) who receive primary and specialty care through a single system of care by 20 percent." We recommend that the Department add a fourth objective: "Implement the CCS Pilot at Rady Children's Hospital." The Whole Child Model is not the only organized delivery system approach being developed and the information gained from the pilot being developed at Rady Children's Hospital will be very helpful as the state considers approaches to integrated care delivery in non-COHS counties.

Response for (California Children's Hospital Association - Organized system of care):
DHCS intends to implement the CCS Demonstration Project (DP) pilot with Rady Children's Hospital San Diego (RCHSD) under the 1115 Waiver. Prior to implementation, RCHSD must satisfy readiness criteria and the contract and deliverables must be approved by the Centers for Medicare & Medicaid Services. RCHSD DP will be a pilot that is limited to: 3 years with 2 one-year options to renew, to the number of enrollees, and to five eligible conditions. As such, DP would not accurately increase the number of CCS children who receive primary and specialty care through a single system of care by 20 percent.

Comment (- Organized system of care):
References to Health Plan of San Mateo Should be Modified.
We have concerns with the Department's characterization of the work of the stakeholder advisory board and its decision to base the CCS Redesign on the Health Plan of San Mateo model, referenced on page 68. The paragraph reads: "In 2014, DHCS initiated another effort to improve the CCS program, CCS Redesign. For CCS Redesign, a stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise.

Response for (- Organized system of care):
DHCS embarked on an extensive six-month stakeholder process for stakeholder feedback in seeking a better integrated and coordinated system, to proceed carefully with changes to the CCS program, and to identify strategies to improve and integrate care for children who qualify for the CCS program. From that process, DHCS developed the "Whole-Child Model" to be implemented in specified counties only.

Comment (California Children's Hospital Association - Organized system of care):
We have concerns with the Department's characterization of the work of the stakeholder advisory board and its decision to base the CCS Redesign on the Health Plan of San Mateo model, referenced on page 68. The paragraph reads: "In 2014, DHCS initiated another effort to improve the CCS program, CCS Redesign. For CCS Redesign, a stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for CYSHCN was created. The goals of this stakeholder process include maintaining a patient and family-centered approach, provide comprehensive treatment for the whole child, improve care coordination through an organized delivery system, improve quality, streamline care delivery, and maintain cost neutrality. Because of the success of the San Mateo Whole Child model, DHCS is proposing to expand this whole child model to other counties with a County Organized Health System, with advisory group feedback. …"[italics added] We believe that this language might suggest that the stakeholder advisory board concluded that the San Mateo model was successful and that this conclusion guided the decision of the Department to select the San Mateo model. The truth is that the stakeholder group has not made such a determination, nor has it been given any data that would allow it to make such a determination, or even agreed upon what outcome measures should be used to evaluate the model. We would suggest that this section could be reworded to say: "The stakeholder advisory group has discussed many alternative approaches to improving care for CYSHCN and several different proposed models for providing high quality care to CYSHCNs in organized delivery systems. Of the models discussed, the Department has selected the San Mateo whole child model for expansion to other counties with a County Organized Health System, and will continue to seek feedback from the advisory group as it moves ahead with the CCS Redesign.

Response for (California Children's Hospital Association - Organized system of care):
DHCS recognizes that an evaluation of the pilot has not yet been completed and will remove reference to "the success of the SM WCM" in the application.

Comment (California Children's Hospital Association - Organized system of care):
Goal to Maintain and Support Regionalized Care Will Require Objectives that Protect Providers from Managed Care Narrow Networks. On Pages 64 and 65 of the draft, the Department identifies a goal of maintaining and supporting regionalized care. However, the objective the Department identifies to achieve this goal is to promote the use of telehealth. While telehealth is certainly an important strategy for improving access to specialty care for families in remote areas, it is certainly not the only objective that will need to be achieve in order to maintain and support access to a regionalized network of specialty providers. Indeed, the carve-in of CCS to managed care has the potential to destabilize the regionalized network of specialty care providers that serve this population, unless the Department works to ensure that plans contract with CCS credentialed providers and follow CCS rules. We recommend that the Department add an objective to this goal: "Establish strong oversight of organized

delivery systems to ensure that these systems utilize CCS credentialed providers to treat CCS-eligible conditions.

Response for (California Children's Hospital Association - Organized system of care):
This Whole-Child Model will maintain the CCS core program integrity and infrastructure including the regional provider network, through the existing DHCS credentialing process, including CCS provider paneling.

Comment (California Hepatitis C Task Force - Organized system of care):
Patient Survey: The DHCS reports that it plans to conduct a family satisfaction phone survey to assess knowledge and satisfaction with the San Mateo demonstration project, etc. (page 68). It is our understanding that the Department conducted a previous survey but has never released the results. Why have the results of this survey not been released as a baseline; and how can the success of the pilot truly be assessed with a second survey when results of the first are not taken into consideration?

Response for (California Hepatitis C Task Force - Organized system of care):
DHCS conducted a family satisfaction phone survey in July-October 2014. The objective of the survey was to assess the families' knowledge and satisfaction with the CCS DP, their knowledge and satisfaction with their care coordinator, their access and satisfaction with providers, and their satisfaction with the medical services provided. The results of the survey were shared with HPSM so they could review areas of success and improvement.

Comment (The Children's Specialty Care Coalition - Organized system of care):
The Coalition recommends the addition of a strategy that acknowledges the Rady Children's CCS Accountable Care Organization pilot, currently under development, as another organized system of care for CCS eligible children.

Response for (The Children's Specialty Care Coalition - Organized system of care):
When approved, the Rady ACO will be noted as another organized system of care in the Title V report. Prior to the CCS Demonstration Pilot (DP) being implemented with Rady Children's Hospital San Diego (RCHSD), RCHSD must satisfy readiness criteria and the contract and deliverables must be approved by the Centers for Medicare & Medicaid Services.

Comment (Children's Regional Integrated Service System - Organized system of care):
2. Develop a methodology to track the number of clients receiving whole child care through CMS Net and/or other DHCS data source. CRISS comments: We recommend that DHCS track the provision of whole child care through current and planned county CCS program oversight, care coordination, and authorization of primary care via CCS SARs

Response for (Children's Regional Integrated Service System - Organized system of care):
DHCS will monitor and provide oversight during and after the transition period. This includes regularly reviewing plan grievances and appeals reports, provider networks, and continuity of care reports.

Comment (Children's Regional Integrated Service System - Organized system of care):
3. With CCS Advisory Group, review options for CCS clients to have a visit with an adult physician through managed care. CRISS comments: See our comments below on transition and recommendation that the state set and Medi-Cal managed care plans be required to meet network adequacy standards for transitioning youth, including increased opportunities for single case agreements if there are no specialists in plan networks appropriate to youths' medical conditions.

Response for (Children's Regional Integrated Service System - Organized system of care):
DHCS and stakeholders are currently engaged in discussions to improve transition of care for CCS children aging out of the CCS Program.

Comment (Children's Regional Integrated Service System - Organized system of care):
Page 67 in this domain: "DHCS has identified priority needs for this domain, in particular for CCS clients, including having standards and policies in place to facilitate the provision of high quality care within an organized care delivery system to all CYSHCN."
From p 16 CRISS comments: We remain concerned that the Department continues to equate "organized delivery system" with Medi-Cal managed care and to assume that the only way for CSHCN to experience coordinated primary and specialty care is to receive both through managed care plans.
CRISS comments: Please see our comments above regarding the importance of a broader definition of "organized care delivery system" for CSHCN.

Response for (Children's Regional Integrated Service System - Organized system of care):
DHCS agrees the definition of an "organized care delivery system" is broad and includes not only the single system of care/whole child approach but also the regionalized network of CCS providers and county CCS programs.

Comment (Children's Regional Integrated Service System - Organized system of care):
"This priority need was a key factor in developing models for the CSHCN portion of the 1115 Waiver of 2010–2015. The first 1115 waiver pilot was initiated in 2013 in San Mateo County through the County Organized Health System, Health Plan of San Mateo. The goal was to have all health care for the CCS child organized within one system. DHCS developed and is currently preparing to administer a family satisfaction phone survey to assess the families' knowledge and satisfaction with the demonstration project, knowledge and satisfaction with their care coordinator, access,

and satisfaction with providers, satisfaction with the medical services provided, and to establish a baseline to compare against future surveys."
CRISS comments: The CCS Advisory Group and others have questioned why DHCS did not require and facilitate evaluation of the HPSM model, including collection of baseline data. It is inaccurate to refer to what HPSM is implementing as a "pilot" if baseline data have not been collected and there have been no collection and analysis of comparison data using specific metrics.

Response for (Children's Regional Integrated Service System - Organized system of care):
The Department is required to conduct an evaluation under the 1115 Medicaid waiver of HPSM and will do so when adequate time has lapsed to conduct such an analysis. The Department has baseline data available to do so.

Comment (Children's Regional Integrated Service System - Organized system of care):
In 2014, DHCS initiated another effort to improve the CCS program, CCS Redesign. For CCS Redesign, a stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for CYSHCN was created. The goals of this stakeholder process include maintaining a patient and family-centered approach, provide comprehensive treatment for the whole child, improve care coordination through an organized delivery system, improve quality, streamline care delivery, and maintain cost neutrality. Because of the success of the San Mateo Whole Child model, DHCS is proposing to expand this whole child model to other counties with a County Organized Health System, with advisory group 5 feedback."
CRISS comments: It is disappointing to have to point this out, but there is no evidence that the HPSM project is a success. Without baseline data and an independent evaluation, there simply is no way for us to tell. In addition, the statement regarding the role of the CCS Advisory Group in promoting expanding the whole child model to COHS counties is misleading on two counts. Most importantly, the Advisory Group has not as a body agreed that the San Mateo model is the best model or even that it is an appropriate model for incorporating CCS into MCMC. In fact, the majority of Advisory Group members have expressed and continue to express concerns about the Department's direction in wanting to fold CCS program functions into MCMC plans. In addition, the DHCS whole child model proposal for COHS counties is not the same as the HPSM model; currently HPSM contracts back with San Mateo County CCS staff, who remain responsible for CCS utilization management, including care planning, case management, and service authorizations. The Department proposal would transfer these responsibilities to the COHS plans with no requirement for continued CCS staff involvement in CCS children's care.

Response for (Children's Regional Integrated Service System - Organized system of care):
DHCS recognizes that an evaluation of the pilot has not yet been completed. The Department is required to conduct an evaluation under the 1115 Medicaid waiver of

HPSM and will do so when adequate time has lapsed to conduct such an analysis. The Department has baseline data available to do so.

Comment (Children's Regional Integrated Service System - Organized system of care):
Currently HPSM contracts back with San Mateo County CCS staff, who remain responsible for CCS utilization management, including care planning, case management, and service authorizations. The Department proposal would transfer these responsibilities to the COHS plans with no requirement for continued CCS staff involvement in CCS children's care.

Response for (Children's Regional Integrated Service System - Organized system of care):

Comment (A CYSHCN client - Organized system of care):
I'm a client of CCS. As I heard a senator once say, "CCS was carved out many years ago for a very valid reason. It is clear it's a complex program servicing complex needs and issues for a finite group of California's children." This senator was absolutely right. The administration believes that the Health Plan of San Mateo was successful. Yet, at the same time they state that they are just now in the process of preparing surveys to get the family and patient input on the success of the model: "DHCS developed and is currently preparing to administer a family satisfaction phone survey ...and to establish a baseline to compare against future surveys." (see pg 68 of the DRAFT Title V 2015 Report 2017 Application Public Document).

Response for (A CYSHCN client - Organized system of care):
DHCS recognizes that an evaluation of the pilot has not yet been completed. The Department is required to conduct an evaluation under the 1115 Medicaid waiver of HPSM and will do so when adequate time has lapsed to conduct such an analysis. The Department has baseline data available to do so.

Comment (Lucile Packard Foundation for Children's Health - Organized systems of care):
Provide high quality care to all CYSHCN within an organized delivery system (P.63): This section recites the litany of existing structures and activities but fails to provide plans likely to improve quality of care. Current quality data are not provided nor are measureable improvement goals. The pediatric palliative care program, apparently found to be effective, does not appear to be slated for growth.

Response for (Lucile Packard Foundation for Children's Health - Organized systems of care):
The CCS program is taking the following steps to improve quality of care within the delivery system: increased communication and data sharing with health plans around clients transitioning to adulthood, and increased facility site reviews. The pediatric palliative care program renewal process is starting which allows modifications to the current program which may make the program more accessible to eligible clients.

Comment (Lucile Packard Foundation for Children's Health - Telehealth):
Maintain and Support Regionalization of Care (P.64): Telehealth is identified as a subsection of this goal, though its relationship to regionalization is not made clear. Currently, use of telehealth for children's health care services in California lags far behind the potential offered by this technology. Reports by The Children's Partnership have identified policy barriers, primarily ones related to billing and coding that could be easily rectified by the Department of Health Care Services. Some of these are addressed in the application, though there remains an absence of a coordinated statewide effort to increase the use of telehealth particularly to address issues of geographic access to specialty and subspecialty care.

Response for (Lucile Packard Foundation for Children's Health - Telehealth):
Thank you for your feedback.

Comment (The Children's Partnership - Telehealth):
SMART Objective Priority 5 (Page 36)
"By June 30, 2020, increase the percent of CCS families reporting that their child always saw a specialist when needed from 72% to 90%, based on CCS/FHOP survey."

Response for (The Children's Partnership - Telehealth):
Agree. DHCS has made the requested change in the application.

Comment (The Children's Partnership - Telehealth):
Telehealth should be added as a strategy to explore to increase the percent of CCS families reporting that their child saw a specialist when needed. The use of telehealth to increase access to paneled providers may make it easier for a provider to sign-up.
Telehealth (last paragraph, Page 64)
"In August 2015, CCHP released a Report: Realizing the Promise of Telehealth for CSHCN, which included findings from this survey."
If possible, it would be nice to recognize the other partners of the report and referenced telehealth project. It was a joint project among The Children's Partnership, Center for Connected Health Policy, and UC Davis.

Response for (The Children's Partnership - Telehealth):
No response provided.

Comment (Children's Regional Integrated Service System - Transition to Adulthood):
Page 64: Goal 3: Improve Transition Services in CYSHCN
SMART OBJECTIVE: By June 30, 2020, increase by 20% the number of 20 year old CCS clients with selected condition who report having an identified adult subspecialist to assume specialty care.

CRISS comments: We appreciate the Department's commitment to achieving smoother, more effective transitions for youth aging out of CCS. CRISS family members talk about transition as one of their most difficult and emotionally fraught experiences as they and their children try to navigate the switch from the pediatric

world to a colder, less family-friendly, and more complicated adult medical world. As you know, CRISS has been working to improve transition in our member counties for many years through the work of our Family-Centered Care and Medical Therapy Program work groups and we are proud of the improvements we have promoted and achieved over the years. We strongly support county activities to improve transition services and we look forward to working within the CCS Advisory Group and the technical work group looking at transition to promote these critically needed services

Response for (Children's Regional Integrated Service System - Transition to Adulthood):
DHCS and stakeholders are currently engaged in discussions to improve transition of care for CCS children aging out of the CCS Program.

Comment (Lucile Packard Foundation for Children's Health - Transition to adulthood):
Improve Transition Services in CYSCHN (P.64): No rate of transition services is proposed as a goal. The application provides a list of the many, fragmented approaches individual counties may be using to improve transition services, but there is no evidence of state leadership, guidance or support. The absence of statewide goals, policies and coordination presents a weak approach to this issue.

Response for (Lucile Packard Foundation for Children's Health - Transition to adulthood):
DHCS will use information gathered in the statewide county transition survey to guide selection of an appropriate step to measure.

Comment (Epilepsy California - Public Comment Period):
The Department posted the document on the Maternal and Child Health webpage on May 11th, providing less than two weeks to review this document. Moreover, the document was not widely distributed and was difficult to locate, even on the Department's website. Given these barriers to public review, more time is needed to carefully review the Department's proposed strategies and outcome measures related to the Title V program. In addition, very little information about the program or the Department's development of its goals has been shared or discussed in public forums. The Department should have regional meetings or conference calls with families and stakeholders to discuss its Title V Program and use these meetings as methods to gather feedback on an ongoing basis.

Response for (Epilepsy California - Public Comment Period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process. DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (Down Syndrome Information Alliance - Public comment period):
..the document was not widely distributed and was difficult to locate, even on the Department's website. Given these barriers to public review, more time is needed to carefully review the Department's proposed strategies and outcome measures related to the Title V program. In addition, very little information about the program or the

Department's development of its goals has been shared or discussed in public forums. The Department should have regional meetings or conference calls with families and stakeholders to discuss its Title V Program and use these meetings as methods to gather feedback on an ongoing basis.

Response for (Down Syndrome Information Alliance - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process. DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (Family Voices of California - Public comment period):
DHCS should solicit public comments during the development of the Application/report. The State should clearly identify specific activities for engaging families and other stakeholders prior to, during and after the Application process – this could be done by: Public hearings; Advisory Council Review (CCS AG stakeholders?); Social media: Public notice

Response for (Family Voices of California - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process.

Comment (Children's Regional Integrated Service System - Public comment period):
We would like to note that the timeframe for responding with comments was exceptionally short (we received the draft on May 18) and request that in the future the public comment period be longer to allow for a more thorough review of draft documents.

Response for (Children's Regional Integrated Service System - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process.
DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (The Children's Specialty Care Coalition - Public comment period):
In the future, it would be helpful if the timeline for comment is longer and the announcement to comment distributed more widely.

Response for (The Children's Specialty Care Coalition - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process.
DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (Family Voices of California - Public comment period):

Public Input – why are families/consumers given less than one week to give input? How are families supposed to give meaningful thought and responses to the application at such short notice (4 days)? For families to digest all 100 pages of application and to sift through (prioritize) what is relevant to them is asking too much. FVCA was asked to send the 100 page application out to families – FVCA pulled out all the pertinent CSHCN information and sent it to families in a word document so they would not be so overwhelmed. We believe they may have just dismissed the opportunity to respond otherwise.

Response for (Family Voices of California - Public comment period):
Moving forward, DHCS will request stakeholder feedback during the application development process.

Comment (California Children's Hospital Association (CCHA) - Public comment period):
CCHA Recommends Department Extend Time for Public Comment The Department posted the document on the Maternal and Child Health webpage on May 11th, providing less than two weeks to review this document. Moreover, the document does not appear to have been widely distributed and was difficult to locate, even on the Department's website. Given these barriers to public review, we would recommend that the Department provide additional time for stakeholders to carefully review the Department's proposed strategies and outcome measures related to the Title V program. In addition, very little information about the program or the Department's development of its goals has been shared or discussed in public forums. The Department should have a public meeting or conference call with families and stakeholders to discuss its Title V Program and use these meetings as methods to gather feedback on an ongoing basis.

Response for (California Children's Hospital Association (CCHA) - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process.
DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (Children Now - Public comment period):
Children Now greatly values and appreciates the opportunity to provide feedback, however, because of the extremely limited time for review, our detailed comments will be restricted to the Action Plan for the Application Year 2016-17 and specific goals within the domains of: Child Health, Children with Special Health Care Needs, and Cross-cutting/Life Course.

Response for (Children Now - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process. DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (California Chronic Care Coalition - Public comment period):

TIMELINE FOR REVIEW AND LACK OF OUTREACH TO STAKEHOLDERS. The Department posted the document on the Maternal and Child Health webpage on May 11th, providing less than two weeks to review this document. Moreover, the document was not widely distributed and was difficult to locate, even on the Department's website. Given these barriers to public review, more time is needed to carefully review the Department's proposed strategies and outcome measures related to the Title V program. In addition, very little information about the program or the Department's development of its goals has been shared or discussed in public forums. The Department should have regional meetings or conference calls with families and stakeholders to discuss its Title V Program and use these meetings.

Response for (California Chronic Care Coalition - Public comment period):
Agree. Moving forward, DHCS will request stakeholder feedback during the application development process.
DHCS will work with MCAH also distribute the document to a larger audience and allow more time for public comment.

Comment (Office of Health Equity - Acronyms):
The document has a lot of acronyms. I would suggest including a list of key abbreviations to facilitate readability.

Response to (Office of Health Equity - Acronyms):
The draft documents released for public comment included the main narrative document and a separate appendix document. Starting on page 8 of the appendix is an alphabetic listing of the acronyms used throughout the main document. (http://www.cdph.ca.gov/programs/mcah/Documents/DRAFT%20APPENDIX%20to%20the%20Title%20V%202015%20Report_2017%20Application%20Public%20Document.pdf)

Be assured that we will include a list of acronyms as an appendix when we release the final report.

Comment (Family Voices of California – Report Translation):
Shouldn't the document also be translated to other languages – Spanish especially? Many opportunities for crucial input/comments are lost without other ethnic groups being represented.

Response to (Family Voices of California – Report Translation):
Thank you for your comment. In a state as diverse as California, MCAH recognizes the need for translation services. Unlike our education materials which are frequently translated to Spanish and other languages upon request, the Title V application/report is a grant application submitted in English that we share with the public prior to submission. Unfortunately, because of the length of the document and the short timeline, we have not attempted to perform translation services. We may explore the feasibility of translating the executive summary in 2017.

Comment (Office of Health Equity - Typo):
A small typo – Health in All Policies Task Force, not Taskforce.

Response to (Office of Health Equity - Typo):
Thank you for your comment. We will make be sure that Task Force is listed as two words throughout the final document.

Appendix 5 Changes to the State Action Plan

Domain: Women/Maternal Health

Goal 1: Decrease Intimate Partner Violence (IPV) – To be more specific, measureable, attainable, realistic and time-bound, Objective 1 was updated to reflect the adoption of an IPV protocol rather than an IPV policy. A protocol is defined as a description of procedures to address IPV. The updated objective states, By June 30, 2020, increase the number/percent of Title V funded programs (i.e., AFLP, BIH and MCAH local health jurisdictions) who adopt MCAH's IPV protocol, including reproductive and sexual coercion from 40% to 60% (2013/14 MCAH Annual Reports).

Six of the original seven key strategies were eliminated and the one remaining strategy was slightly modified to be in step with the theme of the three newly created key strategies. All of the strategies are now more consistently linked and chronologically presented with an emphasis focused upon TA, training, collaboration, and evaluation of activities directed toward establishing viable and effective IPV protocols. The strategies are appropriately reclassified as activities along the causal pathway from the strategy to the outcome.

Goal 2: Decrease Burden of Chronic Disease - There is only one significant change in Objective 2. The change eliminated the key strategy To increase regular well-women visits among women of reproductive age. The remaining four key strategies cumulatively address this and correlate with the NPM #1 – Percent of women with a past year preventive medical visit.

Goal 3: Increase Utilization of Preventive Health Services among Women of Reproductive Age. This goal was moved from Priority 7 in the Cross-Cutting/Life Course Domain and placed within the Women /Maternal Health Domain because the key strategies better correlate with NPM# 1. There were no significant changes other than the elimination of one Key Strategy pertaining to the provision of TA to LHJs regarding development of adequate community resources. The removal of this key strategy may have been predicated upon the loss of staff resources. This could be possibly revisited as key professional personnel are hired over time.

Goal 4: Increase Rate of Women who have pre-pregnancy Health Insurance: The team eliminated the four original key strategies. Of the four original strategies, three of the strategies pertained to developing protocols for the LHJs and MCAH partners. When the teams revisited these strategies, it was agreed that the development of protocols alone would not necessarily increase the rate of insurance coverage among the targeted population. The 4th strategy proposed to partner with the California Health Benefit Exchange Board (CHBEB) to provide input on existing regulations that impact insurance enrollment.

The team developed three new strategies that better aligned with activities associated with increasing rates of health insurance coverage, enrollment, and access to services. Key Strategy 1 requires MCAH to develop a policy and procedure for local

MCAH to increase coverage and access for women. Key strategy 2 requires MCAH to partner with Medi-Cal (not CHBEB) to provide input on regulations that impact enrollment. The move to Medi-Cal and away from CHBEB is because we have past history with Medi-Cal and an interagency agreement with them which bodes well for MCAH in maintaining relations while gaining the necessary input that could improve insurance enrollment. Key strategy 3 requires MCAH to collaborate with LHJs and MCAH programs to implement effective ways of communicating new policies regarding health care access and services.

The original portion of this objective was removed from Priority 7 in the Cross-Cutting/Life Course Domain and placed within the Women /Maternal Health Domain where the key strategies better reflect NPM# 1. This goal also addressed children and adolescents and that portion of the goal pertaining to children and adolescents still remains in the Cross-Cutting/Life Course Domain.

Goal 5: Decrease Rate of Postpartum Women without Health Insurance. The original strategy associated with this goal was removed – Develop an oversight protocol to assure women enrolled in Medi-Cal prenatally receive counseling on postpartum insurance continuation - and replaced by three new key strategies that also encompass the one removed. Policies to increase coverage and access to health care for postpartum women 60 days after delivery, collaborative meetings with MCAH programs to develop a protocol for assessing access to services and linkages to referrals postpartum, and development of a quality improvement process to establish coordinated postpartum referrals after discharge.

Goal 6: Decrease rate of Medi-Cal & Denti-Cal eligible Women without Health Insurance. This goal was moved from Priority 7 in the Cross-Cutting/Life Course Domain and placed within the Women /Maternal Health Domain because the key strategies better correlated with improvements in NPM# 1. Although the key strategies were reduced and streamlined from three to two, the content was actually expanded upon to promote Denti-Cal enrollment.

Goal 7: Decrease Unintended Pregnancy - This objective physically moved within the Action Plan from Objective 2 to Objective 7. There were no significant changes with the strategies in Objective 7 other than identifying the specific resources that will encourage health care providers to use; the National Preconception Curriculum and Resources Guide for Clinicians training module 4 “In Between Time: Interconception Health Care-Part 1: Routine Postpartum Care for Every Woman.”

Goal 8: The goal related to mental health and substance use for adolescents and young adults was moved from the cross-cutting/life course domain to the women/maternal health domain for improved alignment with the logic model and the NPMs and SPMs. The redesigned Objective 2 is: “By June 30, 2020 decrease the rate of mental health and substance use hospitalizations for persons age 15-24 from 1436 per 100,000 and 1754 per 100,000, to 1318 per 100,000 and 1570 per 100,000, respectively.”

The action plan was revised to improve alignment of key strategies and as a result

key strategies 1, 2, 4 and 6 were eliminated. Strategy 2 had emphasized partnering with the CHVP, the CHVP State Interagency Team Workgroup, and Early Childhood Comprehensive Systems (EECS) to identify and address service gaps. The rationale for eliminating this strategy was that it would be included as an activity in a new strategy (#2) related to developing and implementing an evidence-based maternal mental health and wellness toolkit. Strategy 4 was the provision of TA to LHJs. This key strategy was replaced by a new strategy for Title V Programs that more specifically identifies the type of assistance to be provided to these entities. This key strategy (#1) related to increasing awareness of maternal mental health through the development of a health and wellness conceptual model for local MCAH Title V programs and the CHVP.

Key Strategy 3 remained basically the same except for language which was added to specify that MCAH would assist the LHJs with policies and protocols related to maternal mental health and wellness issues. The original Key Strategy 5 is still intact but is now Key Strategy 4. Key Strategies1 and 6 from the original action plan were eliminated as the review team understood that we would be stretching our resources and overextending our efforts in trying to achieve the extensive collaborations and professional staff training that we had originally set forth before us.

Domain: Perinatal/Infant Health

Goal 1: Reduce Pre-Term Births and Infant Mortality – For Objective 1, One Key Strategy was deleted - Develop a plan to ensure coordination of existing perinatal program efforts and avoid duplication of services. The team deemed it unnecessary because accomplishing other strategies within the domain would achieve this indirectly in the process. Another strategy was modified to better convey the nature of the collaboration between local MCAH programs and the RPPC. The focus of the strategy changed from requiring MCAH to establish a relationship with these programs to specifying that MCAH will facilitate the coordination of activities and linkage of services with these programs as a quality improvement effort to prevent preterm births.

Goal 2: Increase Breastfeeding Initiation and Duration – In Objective 2 the first strategy was restructured to be more specific in describing the activity within the strategy. However, the remaining original five strategies were completely broken down and replaced with two strategies that are in direct correlation with the objective and NPM #4. These new strategies are (1) Promote culturally congruent breastfeeding best practices through education, resources, and TA for MCAH funded programs and partners and (2) Build and sustain partnerships and collaborations with national, state, and local partners to promote breastfeeding.

Goal 3: Reduce rate of Sudden Unexpected Infant Deaths – The three strategies remained basically the same except for a modification in strategy 3 to disseminate, rather than promote, the latest infant sleep practices, health education materials and outreach message to LHJs. And rather than engage only fathers regarding safe sleep strategies, both parents would be engaged concerning these safe sleep strategies.

Goal 4: Increase Brief/Bereavement Support Services to Parents/Caregivers of all Babies who Die Suddenly and Unexpectedly – This goal was moved from Priority 7 in the Cross-Cutting/Life Course Domain and placed within the Women /Maternal Health Domain because the strategies better correlate with NPM# 4. There were no changes from what was proposed in the original Action Plan.

Domain: Child Health

The proposed original Priority 3, Objectives 1 and 2 were eliminated. Based on the MCAH internal logic model for these two objectives, it was determined that sufficient staff and resources are not available to perform the activities associated for each of the key strategies. The review team concluded that the outlined key strategies relating to assistance, collaboration, and policy development were unlikely to reduce cases of child abuse. Additionally, it would be difficult to develop new and achievable strategies that would accomplish the Objective without adding more responsibilities for the LHJs; many of which have limited staff.

Deleted Objectives: Objective 1: By June 30, 2020, reduce motor vehicle injury hospitalizations from 11.1 per 100,000 (2103 OSHPD PDD) to 10.6 per 100,000 for children ages 0-5.

Objective 2: By June 30, 2020, reduce substantiated child abuse from 13.0 per thousand for children 0 to 5 years of age (2013 Child Welfare Dynamic Support System) to 12.3 per thousand.

Goal 1: Provide Developmental Screening for Children age 10 months to 5 years: Objective 3, of the original Action Plan, has been renumbered as Objective 1. This objective was corrected to propose an increase of children screened from 28.5 to 29.5% not 38.6 to 40.5%. Also, the ages of the children changed from 12-60 months to 10 to 60 months. The team used many quantitative process measures for the intermediate and long-term outcomes within our logic model and identified the corresponding NPM to be number (6) – developmental screening.

Strategy 4 was eliminated in its entirety because of lack of staff resources at the State level to assist the LHJs in establishing networks and connections among MCAH clinical service providers and other pediatric providers. Two of the remaining three strategies had slight modifications; the most prevalent being in Strategy 1 where the team decided not to try and identify all possible partners as it seemed sufficient to suggest that collaborations would be occurring with multiple relevant partners. The team also decided that it was important for the collaborative efforts to result in the development of goals, objectives, and activities as the means for achieving improvements in the rates of behavioral, social, and developmental screening and linkage to needed services by the targeted population.

Domain: Children with Special Health Care Needs (CSHCN)

Three of the six strategies were eliminated to reduce local responsibilities.

Goal 1: Increase systems that support Children and Youth with Special Health Care Needs (CYSHCN) - The margin of change for Objective 1 was reduced from 20% to 10%. Strategy 1 underwent a name change as CCS Redesign stakeholder was renamed CCS Advisory Group stakeholder. Also, Strategy 2 was modified from – Develop ability to track organization of care in CMS Net, the CCS case management system to – Develop a methodology to track the number of clients receiving whole child care from CMS Net or from another DHCS data source. The justification for this change in Strategy 2 is that CMS Net has limitations in tracking clients in an organized care delivery system. Strategy 3 remained the same.

Goal 2: Increase the number of CCS clients who receive care within a family centered medical home - Objective 2 reduced the margin of change from 20% to 10% and removed the National Survey of Children's Health as the tool by which to measure the success in increasing the number of CSHCN clients who receive care in a medical home. The tool identified for measuring success is now the medical home CCS Performance Measure. The action for Strategy 4 was changed from "identification" to "increasing" the number of counties with liaisons and workgroups to support CSHCN.

Goal 3: Increase the percentage of CCS clients with selected conditions who have a subspecialist to assume specialty care. Objective 3 was changed to increase by 20% the number of 20 year old CCS clients "with a transition planning plan of care documented by CCS staff" instead of having "identified an adult subspecialist to provide specialty care." This change occurred because the transition planning plan of care measure is a new performance measure. Counties will be required to collect the baseline plan of care measure in 2016. The goal is to increase the new baseline measure by 20% in 2017. The justification for the change is that the updated version can be measured as part of a CCS measure while the prior objective depended upon information outside of CCS (i.e., managed care division).

Strategy 1 underwent a name change as CCS Redesign stakeholder was renamed CCS Advisory Group stakeholder. For Strategy 3, the Redesign Stakeholder Advisory Group (RSAB) is now referred to as the CCS Advisory Group. Objective 4 and the six strategies associated with it were eliminated because of a lack of resources.

Goal 4: Increase the percent of CCS families reporting that their child saw a specialist. Key Strategy #1 was changed to remove "streamlining in process and developing reports of shortage areas," and the RSAB Group was changed to CCS Advisory Group. The new strategy reads as follows:

Key Strategy #1 states – With CCS Advisory Group, explore strategies to increase access to CCS paneled providers. The reason for using this updated version is that it can be measured as part of a CCS performance measure while the prior strategy is vague and not measureable.

Goal 5: Increase the number of special Care Centers reporting telehealth services to improve access for underserved CSHCN. This objective was changed from obtaining 100% compliance from CCS counties to report on client use of

telehealth services to 99%. Strategies 1 & 2 remained the same while Strategies 3 & 4 were replaced as follows:

Key Strategy 3: With the CCS telehealth workgroup, assess the current challenges and opportunities to expand use of telehealth for CSHCN, and

Key Strategy 4: Conduct a survey of CCS families and providers to assess perceived access to medically necessary care.

Domain: Adolescent Health

Goal 1: Build Youth Resiliency and Coping Skills to Reduce Bullying. The original Goal 1 was moved to Goal 3. A new Objective 1 was proposed: "By June 30, 2020, promote development of healthy coping skills as indicated by a 10% decrease in the percent of youth (11th graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%. The reason for the change in the objective were the results of the MCAH local needs assessments which supported bullying as a focus area. In addition, the requirement of HRSA to have at least one NPM from each of the six population domains served as a primary reason as well. Thus NPM # 9, related to bullying, was selected as the NPM for this domain. Key strategies identified to address the new objective include expanding the PYD framework throughout adolescent health programs in California. Incorporating the PYD/Resiliency framework through the standardization and integration of PYD principles and strategies into the AFLP programs will build youth resilience in areas of social competence and promote healthy relationships. Training state, AFLP and other Title V funded program staff will improve the implementation of the program elements with fidelity to the evidence-based model.

"By June 30, 2020, increase the rate of AFLP clients enrolled in school from 77.6 percent (2015 AFLP MIS) to 81.5 percent".

Goal 2: Decrease Adolescent Pregnancies – The original Objective 2 "By June 30, 2020, increase the rate of AFLP clients enrolled in school from 77.6 percent (2015 AFLP MIS) to 81.5 percent" and the strategies associated with that Objective were eliminated. Originally decrease adolescent pregnancies was Goal 1 but it was moved to Goal 2. There were no major revisions to Objective 1 to decrease adolescent pregnancies. However, strategy 7 was eliminated – "Develop tools and standards to incorporate PYD principles, resiliency framework and training on healthy coping skills in program implementation and materials."

Domain: Cross-cutting/Life Course

This domain underwent a significant transformation as many of its key strategies and objectives were transferred from the Cross-cutting/Life Course Domain to the Women/Maternal Health Domain where they are more appropriately placed in relation to the NPMs.

Goal 1: Decrease the rate of Medi-Cal eligible children who are uninsured. The objective was edited to be more specific to children. The segment of the original

objective that pertained to women was moved to Goal 6 in the Women/Maternal Health Domain. Strategy 1 remained basically the same but was expanded to include Denti-Cal. Strategy 2 was modified to go a step further than just informing a client of the benefits offered by Medi-Cal. Strategy 2 ensures that persons referred for insurance enrollment complete an appointment. Strategy 3 was eliminated from this objective and moved to Goal 2 as Strategy 2 under Objective 2 where it is more appropriate.

Goal 2: Increase Access to Oral Health: The original Objective 2 for this domain was moved to Objective 3 within the Women/Maternal Health Domain as it addresses well-visits among that population.

The original Objective 8 under the Cross-Cutting Domain - "By June 30, 2020, increase the rate of children ages 3-11 years with a dental visit in the last year from 75.3 percent (2011/12 CHIS) to 79.1 percent" has changed as a result of public comments. With the increased emphasis on early dental visits, it was decided to align this objective with the NPM. The new objective is "By June 30, 2020, increase the rate of children ages 1-17 years who received a preventive dental visit in the last year from 75.3 percent (2011/12 CHIS) to 82.8 percent." The baseline percent figure will remain the same because it was for the 1-17 year old group. However, a 5% improvement was applied to the baseline figure. Because the baseline is from 2011, we applied a 10% improvement for the State Oral Health Plan which gives us a number of 82.8%. This is now Objective 2.

Lastly, while key strategy 1 remains the same, a second Key Strategy was removed from goal 1 above and placed under this objective as key strategy 2 – "LHJ staff inform all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal, promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services."

Goal 3: Increase Utilization of Preventive Health Services among Children: Key strategy 1 was eliminated and replaced by a key strategy that promoted increased coverage and access to preventive services for children 0-17 years old. Key strategy 2 remained the same sans the educating of parents component.

Two new key strategies were added to better align activities associated with local efforts. The new strategies include, "Participate in collaborative meetings with DHCS to improve access to insurance coverage and referral to ancillary health care and public health services such as WIC" and "Collaborate with LHJs and MCAH program to implement effective ways of communicating policies regarding health care access and services."

Goal 4: Increase Rates of Children and Adolescents Who Have Health Insurance: This Objective originally pertained to women, children, and adolescents. However, the woman portion of this objective was moved to Goal 4 in the Women/Maternal Health Domain. The team eliminated the 4 original key strategies, of which 3 of these strategies pertained to developing protocols for the LHJs and MCAH partners. When the teams revisited these strategies, it was agreed that the development of protocols alone would not necessarily increase the rate of insurance

coverage among the population of children and adolescents. The 4th strategy proposed to partner with the California Health Benefit Exchange Board (CHBEB) to provide input on existing regulations that impact insurance enrollment.

The team developed 3 new strategies that better aligned with activities associated with increasing rates of health insurance coverage, enrollment, and access to services. Key Strategy 1 requires MCAH to develop a policy and procedure for local MCAH to increase coverage and access for children and adolescents. Key strategy 2 requires MCAH to partner with Medi-Cal (not CHBEB) to provide input on regulations that impact enrollment. Key strategy 3 requires MCAH to collaborate with LHJs and MCAH programs to implement effective ways of communicating new policies regarding health care access and services.

Goal 5: Increase Physical Activity within the MCAH Population. This goal was previously Goal 2 in Priority 8 in Cross-cutting/Life course. The original Goal 5 in Cross-cutting/ Life course was moved to the Women/Maternal Health Domain as Goal 5 because it is more specific to NPM 1 concerning well-women visits.

The 2 key strategies for this goal were eliminated and replaced with 4 new key strategies that resulted from use of the Logic model that was utilized to assist the team in this area and that were more specific in describing how the Objective would be achieved. The new strategies focused upon the following: (1) Conduct surveillance of weight gain during pregnancy, (2) Provision of best practices about weight gain during pregnancy through TA, education, and resources to MCAH programs and partners for the promotion of environmental change practices and programmatic policies, (3) Promotion of national Dietary Guidelines for Americans and Physical Activity Guidelines, and (4) Developing and disseminating information and tools to assist the MCAH population in meeting dietary guidelines.

Goal 6: Reduce overweight/obesity among low-income children. This goal was originally Goal 3 in Priority 8 of Cross-cutting/Life course. The original Goal 6 in Priority 7 of Cross-cutting/Life Course was moved to Goal 3 in the Perinatal/Infant Health Domain where it more appropriately belongs in relation to NPM 3.

The original Objective for this Goal was – “By June 30, 2020, reduce overweight/obesity among low-income children (ages 2 to 5) from 32.7% (2011 PedNSS) to 31.4%.” The team modified this goal after discussions with WIC and the new Objective is – “By June 30, 2020 reduce the proportion of WIC children aged 2-4 years who are overweight or obese from 34.5 % (WIC PC 2012) to 33.5%.” The original 2 key strategies associated with this Objective were replaced with 2 new key strategies that rely on less resources (eliminates trainings for providers on counseling recommendations). The key strategies do the following: (1) Promote best practices to improve children’s weight status through education and TA for MCAH programs and (2) Build and sustain relationships with national, state, and local partners to promote interventions addressing national guidelines on weight, nutrition, and physical activity.

Goal 7: Increase the rates of physical activity of children, adolescents and women. This was originally Goal 5 in Priority 8 of Cross-cutting/Life course. The original Goal 7 in Priority 7 was moved to the Adolescent Domain where it more appropriately corresponds with NPM 9.

The only change in the Objective was the age range of the women served (from age 18-44 to 18-24). Key strategies 1 & 4 were removed in their entirety as they overextend our limited resources. The original key Strategy 5 was retained but limited specifics as to the entities MCAH would actually be collaborating with. The original key strategies 2 & 3 were combined into one strategy that speaks to culturally congruent best practices promoting national physical activity guidelines & the provision of education, resources and TA for funded MCAH programs.

Also, the Objective in Goal 1 in Priority 8 of the original Action Plan (By June 30, 2020 reduce obesity among reproductive age women from 22% (2013 BRFSS) to 20.7%) was removed in its entirety as Goals 6 & 7 above tend to address this issue.

Goal 8: Increase Consumption of Folic Acid by Childbearing Age Women. This moved from goal 4 in Priority 8. While the Objective remained the same the one Key Strategy changed from ”Continue to provide messaging and guidelines to MCAH programs and contacts,” to “Promote culturally congruent best practices to promote folic acid intake among women of reproductive age among MCAH programs by providing education, resources and technical assistance.”

Appendix 6 State Action Plan Table

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
1. By June 30, 2020, increase the number of Title V funded programs (i.e., AFLP, BIH and MCAH local health jurisdictions [LHJs]) who adopt MCAH's intimate partner violence (IPV) protocol, including reproductive and sexual coercion from 40% to 60% (2013/14 MCAH Annual Reports).	1. Develop and provide capacity building tools for the integration of MCAH's IPV Protocol among Title V funded programs (i.e., AFLP, BIH and MCAH LHJs). 2. Identify, develop and implement culturally congruent trainings, technical assistance and education for implementation and sustainability of MCAH's IPV protocol. 3. Develop and implement IPV Initiative Performance and Quality Improvement (PQI) tools to evaluate the effectiveness of MCAH's IPV protocol and related activities. 4. Build and sustain collaborations and share practices with internal and external partners to support IPV and related efforts.	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
				Preterm-related mortality rate per 100,000 live births
2. By June 30, 2020, MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 OSHPD PDD) to 7.4, 9.5%, 0.51% and 3.9% respectively.	1. Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level. 2. Partner with Office of Health Equity, HiAP Task Force to develop policies and initiatives to address community risk factors for chronic disease (e.g. healthy food availability, built environment, community safety, and ensure applicability to women of reproductive age. 3. Disseminate the National Preconception Curriculum & Resources Guide for Clinicians training module 5 and the Interconception Care Project of California materials to health care providers to ensure women with risk factors receive appropriate interconception and follow up care. 4. Ensure that existing MCAH tobacco prevention and data collection for smoking as a risk factor for chronic	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
	disease include the appropriate references to e-cigarettes.			1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births
3. By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including: (a)Increase the rate of preventive visits from 61.9% (2013 BSMF) to 65.3%; (b) Increase the rate of first trimester prenatal care initiation from 83.6% (2013 BSMF) to 87.9%; and (c) increase the rate of postpartum visits from 88.3% (2012 MIHA) to 92.9%.	1. Develop an oversight protocol for MCAH LHJs to ensure all persons referred for insurance enrollment complete an appointment. 2. Partner and collaborate with DHCS, MCAH LHJs and Programs to promote no-cost preventive services to newly enrolled women of reproductive age, including early entry into prenatal care. 3. Finalize development and pilot test the IRIS (Internal, Reproductive, Integrative, Skin) designation for preventive care visits for young women's health care (a clinician training program to increase utilization of preventive health services by young women, especially low income). 4. Collaborate with Text 4 Baby and hospital partners to schedule and discuss the importance of the postpartum visit during prenatal care and/or labor/delivery and these messages would be delivered to pregnant women through the Text4Baby system.	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
				1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births
4. By June 30, 2020, increase the rate of women with pre-pregnancy health insurance from 75.3% (2012 MIHA) to 79.5%.	1. Develop a policy and procedure for local MCAH to increase insurance coverage and access to services for uninsured and underinsured eligible MCAH population. 2. Partner with Medi-Cal to provide input on regulations that impact enrollment and referral for women of reproductive age and their dependents. 3. Collaborate with LHJs and MCAH program to Implement effective ways of communicating new policies regarding health care access and services.	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
				deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births
5. By June 30, 2020, decrease the rate of postpartum women without health insurance from 16.7 percent (2012 MIHA) to 16.2 percent	1. Develop policies and procedures for local MCAH to increase insurance coverage and access to health care services for postpartum women after 60 days of delivery. 2. Establish collaborative meetings within MCAH Programs to develop a standardized protocol for assessing access to insurance information and services, and linkage and referrals that are made available at postpartum. 3. Develop a quality improvement process involving LHJs and regional perinatal programs to establish coordinated post-partum referrals after hospital discharge.	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births
6. By June 30, 2020, decrease the rate of Medi-Cal eligible women who are uninsured from 8.3%	1. Collaborate with LHJs to provide appropriate client outreach materials and resources to promote Medi-Cal/Denti-Cal enrollment for eligible families and establish a baseline number of families/clients to be	ESM 1.1 - Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are	NPM # 1: Percent of women with a past year preventive medical visit	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
(2011/12 CHIS) to 7.9%.	assisted. 2. LHJ staff inform all eligible and enrolled clients of current available dental benefits offered by Medi-Cal, promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.	referred for enrollment in health insurance and complete a preventive visit		Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births
7. By June 30, 2020, California will reduce the prevalence of	1. Broadly disseminate the concept of a Reproductive Life Plan by developing or disseminating culturally and linguistically		SPM 1 - Percent pregnancies that are mistimed or unwanted among women with a	Severe maternal morbidity per 10,000 delivery hospitalizations

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1%, respectively.	appropriate tools for integration into existing MCAH programs and public health departments. 2. Integrate One Key Question (OKQ) into Title V programs and partner programs to promote appropriate contraception counseling to match pregnancy desire and timing. 3. Standardize the content of the postpartum visit by collaborating with existing partners such as Medi-Cal Managed Care Plans and each LHJ's Perinatal Service Coordinator to use the National Preconception Curriculum & Resources Guide for Clinicians training module 4 "In Between Time: Interconception Health Care Part 1: Routine Postpartum Care for Every Woman." 4. Promote through collaboration with existing partners such as Medi-Cal Managed Care Plans and each LHJs Perinatal Service Coordinator the importance of attending the postpartum visit to patients during prenatal care and labor/delivery.		recent live birth.	Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%) Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality per 100,000 live births
8. By June 30, 2020,	1. Increase local MCAH programs		NPM # 1: Percent of	Rate of severe maternal

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
decrease the rate of mental health and substance use hospitalizations for persons age 15-24 from 1436 per 100,000 and 1754 per 100,000, to 1318 per 100,000 and 1570 per 100,000, respectively	awareness of maternal mental health and wellness issues that impact MCAH target populations through various educational opportunities. 2. Develop and distribute an evidence-based Maternal Mental Health and Wellness Toolkit for local MCAH programs. 3. Develop culturally and linguistically appropriate policies and protocols for LHJs and MCAH Programs to reduce discrimination, disparities, and stigmatization related to maternal mental health and wellness issues. 4. Develop and implement evidenced based screening and brief intervention policies that require all Title V funded programs and initiatives to screen participating women and adolescents to determine if they are at risk for mental health and substance use disorders and refer, link, and provide a brief intervention to those who screen positive.		women with a past year preventive medical visit	morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Women/ Maternal Health				
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.				
				rate per 100,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Perinatal/ Infant Health				
Priority 2: Reduce infant morbidity and mortality				
1. By June 30, 2020, decrease the percentage of preterm births, less than 37 completed gestational weeks, from 8.8% (2013 BSMF) to 8.3%.	1. Define new and existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction. 2. Facilitate the coordination of perinatal activities between MCAH LHJs and the Regional Perinatal Programs of California by supporting the local perinatal advisory councils to provide regional planning, coordination and recommendations to ensure appropriate levels of care are available and accessible to high risk pregnant women and their infants; conducting regional hospital assessments and providing technical assistance; developing a communication network among agencies, providers and individuals; disseminating educational materials and providing resource directories and referral services. 3. Co-lead the California Prematurity	ESM 3.1 Percent of facilities with a plan for transport out of complicated obstetric/ maternal patients.	NPM # 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU	Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Preterm-related mortality rate per 100,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Perinatal/ Infant Health				
Priority 2: Reduce infant morbidity and mortality				
	Leadership Council and integrate prematurity prevention strategies that are recommended into relevant MCAH program curricula and activities with a focus on reduction of preterm births in the African-American population. 4. Assist local agencies/partners in developing materials to educate pregnant women/women of reproductive age on the signs and symptoms of preterm labor.			
2. By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2%	1. Conduct surveillance and evaluation of breastfeeding outcomes, including measurement of trends and disparities in breastfeeding initiation, duration and exclusivity, and the quality of maternity care related to breastfeeding. 2. Promote culturally congruent breastfeeding best practices by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies. 3. Build and sustain partnerships and collaborations with national, state and local partners to promote breastfeeding.	ESM 4.1: Percent of births that occur in facilities that provide recommended care for lactating mothers and their babies.	NPM #4A: Percent of infants who are ever breastfed NPM #4B: Percent of infants breastfed exclusively through 6 mos.	Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 100,000 live births
3. By June 30, 2020,	1. Provide the latest American	ESM 4.1: The	NPM #4A:Percent of	Post neonatal mortality rate

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Perinatal/ Infant Health				
Priority 2: Reduce infant morbidity and mortality				
reduce the rate of Sudden Unexpected Infant Deaths (SUIDS) from 54.4 per 100,000 live births (2013 BSMF) to 50.3 per 100,000.	Academy of Pediatrics (AAP) guidelines on infant safe sleep practices/Sudden Infant Death Syndrome (SIDS) risk reduction through two SIDS trainings each year, and the Annual SIDS Conference for SIDS coordinators, public health professionals, and emergency personnel. 2. Update SIDS curriculum to include current recommendations on infant safe sleep practices, SIDS risk reduction for hospital staff, and childcare provider training sessions. 3. Disseminate to LHJs the latest infant safe sleep practices, SIDS risk reduction health education materials, messages to outreach and engage parents of infants regarding safe sleep practices	proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies.	infants who are ever breastfed NPM #4B:Percent of infants breastfed exclusively through 6 months	per 1,000 live births Sleep-related SUID per 100,000 live births
4. By June 30, 2020, 100% of parents/caregivers experiencing a sudden and unexpected infant death will receive grief/bereavement support services .	1. Contact local coroner offices to remind and encourage referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death. 2. Make grief/bereavement support materials and peer support organizations available on the California SIDS Program website. 3. Provide training on grief and bereavement support services to	ESM 4.1: The proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies.	NPM #4A:Percent of infants who are ever breastfed NPM #4B:Percent of infants breastfed exclusively through 6 months	Post neonatal mortality rate per 1,000 live births Sleep-related SUID per 100,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Perinatal/ Infant Health				
Priority 2: Reduce infant morbidity and mortality				
	public health professionals and emergency personnel who respond to sudden unexpected infant deaths. 4. LHJs contact families who experience a sudden unexpected infant death from which a referral was received from the local coroner's office to provide grief/bereavement support.			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Child Health				
Priority 3: Improve the cognitive, physical and emotional development of all children				
1. By June 30, 2020, increase the rate of children ages 10 months to 5 yrs. screened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool during a healthcare visit from 28.5 percent (2010/11 NSCH)	1. Collaborate with relevant partners to develop goals, objectives, and activities to improve rates of behavioral, social, and developmental screening and linkage to needed services for all children and youth; especially children ages 10-60 months and at-risk populations. 2. Provide technical assistance to MCAH programs to promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials and support MCAH LHJs to develop protocols and pathways to refer children needing services to evidence-based screening and referral systems to ensure children	ESM 6.1: No. of LHJs that implement at least two core components of the Help Me Grow System that connects at-risk-children for developmental and behavioral problems with services they need.	NPM 6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.	Percent of children in excellent or very good health Percent of children meeting the criteria developed for school readiness

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Child Health				
Priority 3: Improve the cognitive, physical and emotional development of all children				
to 29.5 percent.	and youth with special health care needs (CYSHCN) are identified early and connected to needed and ongoing services. 3. Assist MCAH LHJs to develop and adopt policies to provide developmental screening, referral and appropriate linkages for all children and youth in MCAH programs using a parent-completed screening tool or other validated tool; provide technical assistance to incorporate quality assurance and quality improvement plans into policies and tools.			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: CSHCN Health				
Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.				
1. By June 30, 2020, increase the children enrolled in the California Children's Services (CCS) who receive primary and specialty care through a single system of care by 10% from 7104 currently to 7814.	1. Through the CCS Advisory Group stakeholder process, refine the selected whole child approach to optimize access to qualified providers. 2. Develop a methodology to track the number of clients receiving whole child care through CMS Net and/or other DHCS data source. 3. Conduct surveys of CCS families and providers to assess satisfaction with organized care delivery system.	ESM 11.1. Number of county CCS programs with family members providing input into CCS medical home policies.	NPM 11: Percent of children with and without special health care needs having a medical home	Percent of CSHCN)receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
2. By June 30, 2020 increase the number of CSHCN who receive care within a medical home by 10%, as measured by the medical home	1. With CCS advisory group, review existing national, state, and local medical home models and tools and identify best methods for CCS to promote medical homes for CSHCN. 2. Explore integration of ACA health home concept with the medical	ESM 11.1. Number of county CCS programs with family members providing input into CCS medical home policies.	NPM 11: Percent of children with and without special health care needs having a medical home	Percent of CSHCN)receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: CSHCN Health				
Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.				
CCS performance measure.	home concept. 3. Develop and disseminate materials to facilitate medical home implementation of tools that promote medical homes including medical home binders and medical home standards. 4. Increase the number of counties with family advisory council parent health liaison family-centered care workgroup or other role supporting CSHCN including CCS.			through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
3. By June 30, 2020, increase by 20% the number of 20 year old CCS clients with a transition planning plan of care documented by CCS county staff.	1. Explore current CCS transition practices including transition fair, parent liaisons, and the CCS Advisory Group transition workgroup findings. 2. Increase the number of family members providing input into state and local transition practices. 3. With CCS Advisory Group, review options for CCS clients to have a visit with an adult physician through managed care.	ESM 12.1 Percentage of county CCS programs with family members providing input into transition policies.	NPM 12: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: CSHCN Health				
Priority 5: Increase access to CCS-paneled providers such that each child has timely access to a qualified provider of medically necessary care.				
1. By June 30, 2020, increase the percent of CCS families reporting that their child always saw a subspecialist when needed from 72% to 90%, based on CCS/FHOP survey.	1. With CCS AG, explore strategies to increase access to CCS-paneled providers, with focus on rural areas. 2. Based on the findings of the Title V needs assessment, define issues associated with non-participation in CCS of durable medical equipment, pharmacy, home health and behavioral health providers, and explore methods to increase their participation in CCS.	ESM 11.1. Number of county CCS programs with family members providing input into CCS medical home policies.	NPM 11: Percent of children with and without special health care needs having a medical home	Percent of CSHCN receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
2. By June 30, 2020,	1. Develop a system within CMS Net or	ESM 11.1. Number of	NPM 11: Percent of	Percent of CSHCN

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: CSHCN Health				
Priority 5: Increase access to CCS-paneled providers such that each child has timely access to a qualified provider of medically necessary care.				
99% of county CCS programs will report on use of telehealth services.	Medi-Cal to track use of telehealth services for CCS clients. 2. Establish CCS telehealth workgroup with stakeholders including families, to build upon previous work assisting DHCS in telehealth implementation. 3. With workgroup, assess current challenges and opportunities to expand use of telehealth for CSHCN. 4. Conduct survey of CCS families and providers to assess perceived access to medically necessary care.	county CCS programs with family members providing input into CCS medical home policies.	children with and without special health care needs having a medical home	receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Adolescent Health				
Priority 6: Increase conditions in adolescents that lead to improved adolescent health.				
1. By June 30, 2020, promote development of healthy coping skills as indicated by a 10% decrease in the percent of youth (11th graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%.	1. Develop policies and procedures for AFLP grantees to incorporate the Positive Youth Development (PYD)/Resiliency framework into programs that serve adolescents. 2. Train state and local staff on the principles of PYD, resiliency and healthy coping skills for adolescents	ESM 9.1: Percent of Adolescents who complete the AFLP PYD evidence-informed program model	NPM #9: Percent of adolescents, ages 12 -17 years, which are bullied or bully others.	Adolescent mortality, ages 10 through 19 per 100,000 Adolescent suicide, ages 15 through 19, per 100,000
2. By June 30, 2020, decrease the adolescent birth rate from 23.2 per 1000 females, 15-19 years of age (2013 BSMF), to 19.8 per 1000.	1. Target all MCAH adolescent sexual health programs to high need and/or historically underserved populations to reduce disparities. 2. Implement evidence-based or evidence-informed interventions in all MCAH funded adolescent sexual health programs aimed at educating adolescents on preventing pregnancy and sexually transmitted infections (STIs) including HIV. 3. Educate adolescents in all MCAH-funded adolescent health programs regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods. 4. Provide adolescents participating in		SPM 2: Percent of births among adolescents, ages 15-17years.	Severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%)

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Adolescent Health				
Priority 6: Increase conditions in adolescents that lead to improved adolescent health.				
	MCAH- funded adolescent sexual health programs information on and/or linkages to reproductive health services that are affordable, accessible, confidential, and youth-friendly. 5. Identify gaps in the availability of youth-friendly reproductive health services on an ongoing basis to inform local program strategy and statewide collaboration. 6. Develop and implement youth-informed programs to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.			Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality per 100,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 7. Increase access and utilization of health and social services				
1. By June 30, 2020, decrease the rate of Medi-Cal eligible children who are uninsured from 36.5% (2011/12 CHIS) to 34.7.	1. Collaborate with LHJs to provide appropriate client outreach materials and resources to promote Medi-Cal/Denti-Cal enrollment for eligible families and establish a baseline number of families/clients to be assisted. 2. Develop an oversight protocol for	ESM 15.1: No. of individuals in MCAH Programs that were referred to Medi-Cal, Covered California or other health insurance.	NPM 15. Percent of children 0 through 17 years who are adequately insured	Percent of children in excellent or very good health Percent of children without health insurance

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 7. Increase access and utilization of health and social services				
	MCAH LHJs to ensure all persons referred for insurance enrollment complete an appointment.			
2. By June 30, 2020, increase the rate of children ages 1-17 years who received a dental visit in the last year from 75.3 percent (2011/12 CHIS) to 79.1 percent	1. Under the guidance of the CDPH Oral Health Director, MCAH and Chronic Disease and Injury Control Division will collaborate to develop the State's oral health plan to identify priorities, goals, objectives and key strategies. 2. LHJ staff informs all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal, promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services. 3. Under the guidance of the CDPH Oral Health Director, MCAH and Chronic Disease and Injury Control Division will collaborate to implement the newly funded California Children's Dental Disease Prevention Program.	ESM 15.1: No. of individuals in MCAH Programs that were referred to Medi-Cal, Covered California or other health insurance.	NPM 15. Percent of children 0 through 17 years who are adequately insured	Percent of children in excellent or very good health Percent of children without health insurance
3. By June 30, 2020, increase the rate of children, ages 0 to 17 years, who receive one or more preventive visits in the last 12 months from 80.6% (2012	1. Develop policies and procedures for MCAH LHJs to increase insurance coverage and access to preventive services for children 0-17 years old. 2. Integrate preventive care concepts for children and adolescents into MCAH program curricula.	ESM 15.1: No. of individuals seen at local health jurisdictions that were referred to Medi-Cal, Covered California or other health insurance.	NPM 15. Percent of children 0 through 17 years who are adequately insured	Percent of children without health insurance Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 7. Increase access and utilization of health and social services				
NSCH) to 84.6%.	3. Participate in collaborative meetings with DHCS to plan effective activities to improve access to insurance coverage and referral to ancillary health care and public health services such as WIC. 4. Collaborate with LHJs and MCAH program to implement effective ways of communicating new policies regarding health care access and services.			
4. By June 30, 2020, increase the rate of children and adolescents (age 0-17) with health insurance from 74.4% (2102 NSCH) to 78.2%.	1. Develop a policy and procedure for local MCAH to increase insurance coverage and access to services for uninsured and underinsured eligible MCAH population. 2. Partner with Medi-Cal to provide input on regulations that impact enrollment and referral for women of reproductive age and their dependents. 3. Collaborate with LJHs and MCAH program to Implement effective ways of communicating new policies regarding health care access and services.	ESM 15.1: No. of individuals in MCAH Programs that were referred to Medi-Cal, Covered California or other health insurance.	NPM 15. Percent of children 0 through 17 years who are adequately insured	Percent of children without health insurance Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.				
1. By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%	1. Conduct surveillance of weight gain during pregnancy, including measurement of trends and disparities. 2. Promote culturally congruent best practices about weight gain during pregnancy by providing technical assistance, education and resources to funded MCAH Programs and partners for the promotion of environmental change practices and programmatic policies. 3. Promote the national Dietary Guidelines for Americans and Physical Activity Guidelines weight assessments, counseling and referrals for all women. 4. Identify or develop and disseminate information and tools through key partners (NEOP, WIC, CDE, Systems of Care, EMSA) to help the MCAH population meet the dietary guidelines for Americans.		SPM 3. Percent of women with the appropriate weight gain during pregnancy.	

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.				
2. By June 30, 2020 reduce the proportion of WIC children aged 2-4 years who are overweight or obese from 34.5% (WIC PC 2012) to 33.5%	1. Promote culturally congruent best practices to improve children's weight status by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies. 2. Build and sustain partnerships and collaborations with nation, state and local level partners to promote interventions to address national guidelines on weight, nutrition and physical activity for young children.		SPM 1. Percent of women with the appropriate weight gain during pregnancy.	
3. By June 30, 2020, increase the rate of meeting the age specific guidelines for physical activity from 30.4%, 16.2% (2011-12 CHIS) and 24% (2013 BRFSS) to 31.9%, 17% and 25.3% for children ages 6-11, adolescents 12-17, and women ages 18-24 respectively.	1. Promote culturally congruent best practices to promote national physical activity guidelines by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies. 2. Build and sustain partnerships and collaborations with national, state and local level partners to promote physical activity within the MCAH population.		SPM 1. Percent of women with the appropriate weight gain during pregnancy.	
4. By June 30, 2020, increase the percentage of	1. Promote culturally congruent best practices to promote folic acid intake among women of reproductive age		SPM 1. Percent of women with the appropriate weight gain	

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
Domain: Cross-cutting/ Life course				
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.				
women who took a vitamin containing folic acid every day of the week during the month before pregnancy from 34% (2012 MIHA) to 35.9%	among MCAH programs by providing education, resources and technical assistance.		during pregnancy.	